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LONG-TERM CARE ASSISTANCE ACT OF 1988

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

SECOND SESSION

ON

S. 2305

MAY 27, AND JUNE 17, 1988

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LONG-TERM CARE ASSISTANCE ACT OF 1988

FRIDAY, MAY 27, 1988

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 9:35 a.m. in Room SD-215, Dirksen Senate Office Building, Hon. George J. Mitchell (chairman of the subcommittee) presiding.

Present: Senators Mitchell, Baucus, Rockefeller, Daschle, Packwood, Chafee, and Durenberger.

Also present: Ms. Kathy Gardner Cravedi, Staff Director, Subcommittee on Health and Long-Term Care of the House Committee on Aging.

[The prepared statement of Senator Mitchell appears in the appendix.]

[The press release announcing the hearing follows:]

[Press Release No. H-10, May 27 and June 17, 1988]

FINANCE SUBCOMMITTEE ON HEALTH TO HOLD HEARINGS ON LONG-TERM CARE

WASHINGTON, DC—Senator George Mitchell (D., Maine), Chairman of the Senate Finance Subcommittee on Health, announced Friday that the Subcommittee will hold hearings on S. 2306, the Long-Term Care Assistance Act of 1988. The first hearing will focus on program benefits provided under the bill, and the second hearing will examine the role of private insurance.

The hearings are scheduled for *Friday, May 27, and June 17, 1988 at 9:30 a.m.* in Room SD-215 of the Dirksen Senate Office Building.

Mitchell said "The problem of providing long-term care for the nation's growing elderly population is one of the most serious issues facing Congress today.

"The current system causes disruption and hardship for the families of those people needing nursing home, home health and respite care services," Mitchell said. "These hearings will examine solutions offered in the Long-Term Care Assistance Act, and will serve as a starting point for the Senate's debate on the issue of long-term care."

OPENING STATEMENT OF HON. GEORGE J. MITCHELL, A U.S. SENATOR FROM MAINE, CHAIRMAN OF THE SUBCOMMITTEE

Senator MITCHELL. Good morning, ladies and gentlemen. Today, we begin consideration and examination of the long-term Care Assistance Act of 1988. The intent of this bill is to address the very real problems faced by our citizens when they or a person in their family need long-term care.

The emotional and financial toll exacted in the current situation is enormous. When I speak to elderly citizens in Maine and in other States about the concerns they have for the future, The fear of the cost of long-term care is almost always mentioned.

It is a fear of financial catastrophe. It is a fear of having to leave home because they would have no way to pay for home health care. It is a fear of being a burden on their families.

Why do we have such a problem? First, because Americans are growing older. In 1900, one in 25 Americans was over the age of 65; in 1986, one in eight was at least 65. The elderly population is itself growing older. In 1986, about 40 percent of the population was 75 years old or older; by the year 2000, 50 percent of the elderly population is projected to be over the age of 75.

In addition to the aging of the population in general and the increase in the very elderly population in particular, a second demographic factor has a profound impact on the need for long-term care. That is the aging of the baby boomers, those born between 1945 and 1960.

As that group moves through the latter stages of life, its numbers will strain our capacity to provide health care for all of our citizens.

And a significant fact is that while today 12 percent of the population is over age 65, in the year 2030 that number will almost double. We must plan for this significant change.

As the population ages, particularly beyond the age of 85, the need for long-term care for chronic illness increases dramatically. While only approximately five percent of the elderly reside in nursing homes, a tremendous share of the financial resources of the elderly and their families, as well as of State and Federal Governments, are spent on that institutional care.

When we began work on the Catastrophic Care Protection Act, the large void in long-term care became even more apparent. This bill, the subject of today's hearing, was developed to deal with that need.

The reality is that, as a Nation, we do not have a long-term care policy. Services available to the elderly for long-term care are not coordinated or adequately financed. Most elderly persons who require nursing home care must either be wealthy enough to pay for that care themselves—and there are very few in our society who can do so—or they are forced to impoverish themselves to become eligible for Medicaid, insurance for the poor.

The current Medicare home health benefit is not adequate to meet the needs of those who might be able to remain in their homes, indeed who most often prefer to remain in their homes if a better range of benefits were available. There is currently no Federal support for respite care or adult day care.

In short, existing long-term care services available to the elderly are inadequate, poorly coordinated, and under financed. This bill is the product of more than a year's work and discussion with some of the best minds in the country on the subject of long-term care.

I welcome the opportunity to discuss this complex subject with many experts in the fields of aging, health insurance, and finance. I hope this bill will stimulate debate and focus our thinking so that we may come to a consensus on this difficult but very important matter.

I expect and welcome constructive criticism of this bill. All aspects of long-term care policy ought to be explored so that a well thought-out policy results. I look forward to the comments of the distinguished witnesses here today as the next step in the important task of developing a national health long-term care policy.

I am pleased to be joined by several of our colleagues here, the distinguished former chairman of the committee, Senator Packwood. Senator, do you have an opening statement you care to make?

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON

Senator PACKWOOD. Thank you, Mr. Chairman. There is no question but what Congress is going to enact some type of long-term care bill. I don't think it is going to be in this session of Congress, but we will enact it surely before the next Congress is out.

And whatever we put in place will probably be what will stay in place, even if it is a bad bill; it will be the bill that will stay in place for a decade, a generation, maybe forever.

As I look at the way that we attempt to pay medical costs in this country—both the way we pay them privately and the way we pay them publicly—I find that the tax laws or the trade laws are a sea of simplicity in comparison to the way we attempt to pay medical costs. They are far and away the most complex part of the law that this committee deals with, and I am not convinced they are all together fair. I am reasonably convinced they are quite inefficiently provided.

So, now we are going to start down a road on long-term care. Here we have a country that spends as much as any country in the world of its total gross national product on health, if you count what we spend publicly and what we spend privately.

And yet, I question whether we get any better health treatment than many other countries of the world that somehow spend less; and in some cases, they are countries that we would regard as, if not primitive, certainly not advanced capitalistic societies and yet have reasonably good health care.

In retrospect, I wish that 50 years ago employers had included retirement health coverage with that health coverage that they provided for their employees; and today, we would probably not have a Medicare Program. We would have the equivalent of a Medicaid Program for those people who fell between the cracks; but employers didn't do that.

So, we have Medicare, and we should have. I wish that 50 years ago employers had started to provide long-term health coverage for their retirees, but they didn't. I am not here to criticize them. For whatever reasons, the unions didn't ask for it in bargaining; employers didn't offer it; and we didn't do it.

And so, we more or less find ourselves now, in terms of long-term health coverage, where we were when we considered Medicare a quarter of a century ago. I hope we can do everything possible to encourage private sector participation in the providing of long-term care, but we must not forget that there will be people who will not have private coverage, who cannot afford private coverage, employers who do not provide private coverage.

And we cannot simply wave our hand and say, gee, that is too bad. Too bad for Sally or too bad for Jim that they happen to work for the wrong employer or they happen to live in the wrong State. Those people cannot be left out.

I hope in our desire to pass a decent bill, we do not pass one that makes it very difficult for the private sector to get in; and I hope we learn from many of the mistakes we have made as to how we regulate, provide, and pay for medical coverage so that we don't extend those mistakes to long-term care.

Thank you, Mr. Chairman.

Senator **Mitchell**. Thank you, Senator Packwood. In accordance with the committee's rules, the opening statements and questioning will occur in the order in which the members appeared; and next is the distinguished Senator from West Virginia, Senator Rockefeller.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER, IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator **Rockefeller**. Thank you, Senator Mitchell. Mr. Chairman, I also thank you for holding this hearing on the Long-Term Care Assistance Act of 1988. Your leadership on this very important issue is admirable, as is your commitment whenever it comes to matters of health.

I still recall you in the recent conference on reconciliation, grappling with a number of very serious issues. I think you had a temperature of about 103 or 104; you were basically sick. You should have been at home or in a hospital, but you hung in.

Senator **Mitchell**. I couldn't afford it. (Laughter)

Senator **Rockefeller**. Because of what you couldn't afford, America is a lot better off.

The American people clearly want Congress to act on the need for long-term health care coverage; and while it is obvious that Medicare, Medicaid, other Government programs and private health insurance must be expanded to cover long-term care, it is by no means a simple or inexpensive goal to accomplish.

Thanks to the leadership of Senator Mitchell, Senator Bentsen and the rest of our committee, we are close to enacting catastrophic legislation that will primarily improve Medicare coverage of acute care for the elderly. And perhaps there was a feeling after that, Senator Pepper, that we could all go home and rest from our labors; but that is not the case and that cannot be the case.

I think we knew that, when we made the commitment to focus on catastrophic health care expenses, we would have to act on long-term care. It is time to respond to the enormous problems that befall the elderly, when they suddenly encounter the need for ongoing long-term care at home, in a nursing home, or some other setting.

Care in these cases may not require the sophisticated medical technology of hospital care. It is as vital, however, to our elderly and their ability to continue living, functioning, and remaining as comfortable as possible.

Making long-term care affordable and available is, in my judgment, a financial and human problem of greater importance. We must answer questions on who should pay, how much will it cost, and how to divide the responsibilities among Government, the private sector, and beneficiaries, as Senator Packwood just referred to.

More specifically, we have to make it so that elderly no longer will be forced to impoverish themselves when they or their spouses need long-term health care and assistance. I believe the Long-Term Care Assistance Act serves as a fundamental first step toward solving this problem and filling in the gaps.

I should also note that I am pleased to be a cosponsor of Senator Durenberger's Rural Long-Term Care Demonstration Act, which deals with concerns about the availability of long-term care services. This legislation will test various ways of providing care in rural areas and finding out what works best.

Some people think, Senator Pepper—and you are not one of them—that health care for the elderly is an urban problem and that somehow living in the bucolic settings of Appalachia or Northern Minnesota or other distant places puts all questions to rest.

It is quite the opposite in my judgment. Almost all of our seniors in West Virginia are poor. When I was governor, we initiated a very modest program called the Golden Mountaineer Discount Program, to give seniors discounts at certain stores.

Members of the legislature thought that it was a boondoggle and said that seniors can pay for their groceries; seniors can pay for things the way others can. And I said fine; we will find out how many of them are rich and how many of them are poor.

And we ran the test, and we found out that four percent of our seniors in West Virginia were wealthy, and the rest were not. The problems are overwhelming.

Your leadership is crucial. Your bill is formidable. Between what you are talking about and what Senator Mitchell is talking about and what our various committees will do to fulfill our responsibility to the aged in the Congress, I have confidence that we will solve this problem responsibly and humanely.

Thank you, Mr. Chairman.

Senator MITCHELL. Thank you very much, Senator Rockefeller. I am pleased also to be joined by the former chairman of this subcommittee, who served for 6 years with great energy and leadership and has been a leader in the area of health care for the elderly, Senator Durenberger.

OPENING STATEMENT OF HON. DAVID DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Mr. Chairman, thank you very much, and thank you for this opportunity. You made reference to your bill and the fact that you have some of the best minds in the country working on it; and I think all of us have been doing that for a long time.

I had 12 hearings in January of this year with what I thought were the best minds in the country, which were my constituents back in Minnesota—in northern Minnesota, central Minnesota, southern Minnesota, and the metropolitan areas. And like all of us, I still tend to think that some of the best sources of information on trying to resolve this problem or take advantage of this opportunity are the constituents who, in one way or another, end up making the choices that need to be made for care and then helping to finance those choices.

I said yesterday, Mr. Chairman, at a hearing we had on another generation—the problems of children in this country—that one of the things that this generation needs to celebrate is the fact that we have finally achieved a point where we don't automatically povertize the elderly when they turn 65.

While a lot of people go around saying—every time they write a story—how well off the elderly are, and they show my parents sitting in a spa in Senator Pepper's home State. I think most of us celebrate the fact that they aren't in the poor house once they reach 65 or 70.

But what we also celebrate in this country is that medical science and all of the technology that has raised the price of going to the hospital or the doctor—as for the chairman of this subcommittee—has also made it possible for my parents to live so much longer than the elderly have ever lived before.

Invariably, in the hearings I have in my State we talk about dementia and Alzheimer's Disease. Somebody will say: Well, 10 years ago I took my husband to the Mayo Clinic, and he was diagnosed as having Alzheimer's, and I thought the doctor said "old-timer's" disease.

The reality is that today we are all experiencing a variety of chronic illnesses that probably have always been with us. It is just that so many more people today are experiencing them in such a wide variety of ways, and we are committing resources to their solution; but now the problem seems to be much larger, and the imperative is much stronger.

One of the urgencies, I suppose, in addressing this problem from my standpoint is that we have been doing that in this committee for the last 10 years that I have been here, Mr. Chairman. This isn't something new.

Maybe the focus on long-term care is new, but this committee has spent a lot of time on this. One of the knocks on Senator Pepper's bill is there haven't been any hearings on the bill. We have been having hearings on this subject for the 10 years I have been here.

So, while we may not have had a hearing specifically on your bill or on his bill, this committee has been having hearings on this subject for a long, long time. It is out of this committee that some of the long-term channeling demonstration programs came, and we have that going all over the country.

People on this committee were fighting with Dave Stockman in 1981 and 1982 to permit the social HMO demonstrations around this country; and people on this committee continue to fight with HCFA on Medicare waivers for community-based programs.

So, it isn't as though we haven't been at this for some period of time. I think the problem that we face is that all of these demonstrations and all of these experiments out there haven't really given us a clear path for us to follow. So, we tend to take whatever is the most attractive path, in one way or another; and as our catastrophic efforts have indicated to us, sometimes the most attractive is not necessarily the most beneficial.

And I guess what the chairman is starting today on our behalf is a path to a result that is both attractive and beneficial in a financial sense and in a way in which we can stop using these high cost medical dollars to provide social services and housing services and things like that for people, but do what we need to do in a way that provides a greater set of benefits to a larger number of people.

Senator MITCHELL. Thank you very much, Senator Durenberger.

Just 48 hours ago, the House/Senate Conference on the Catastrophic Care Bill reached agreement, after several weeks of intense negotiations; and one of the principal reasons why we reached agreement is seated to my right, Senator Baucus, who was a member of the subcommittee that crafted the compromise on the prescription drug provision and whose contributions repeatedly broke logjams and enabled us to reach agreement on that historic bill. So, we are very pleased to have Senator Baucus here today.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you, Mr. Chairman. This obviously is the next major step that this Congress and this country will take in health care. I don't have any lengthy statement, except to say that I commend Senator Pepper, who has worked very long and hard in this and other areas related to health.

I commend you, Mr. Chairman, Senator Durenberger, and others. I hope that we can lay new groundwork this year. Even though we will not enact long-term health care legislation this year, it is my hope that we can make a very major new contributions to our understanding, to look forward to a solution that we will enact next year.

So, I commend you and the witnesses, and I look forward to getting on with it this year so that we can do a better job next year. Thank you.

Senator MITCHELL. We are particularly honored to have as our first witness Senator Claude Pepper, Chairman of the House Rules Committee, one of America's best known citizens and one who has devoted a lifetime of public effort to improving the lives of other Americans.

Senator, we are grateful for all you have done, for your continuing contribution. By your very presence, you serve as a symbol of what Americans can do through a long and healthy life, and we are grateful for all of your efforts and your willingness to share your views with us here today.

STATEMENT OF HON. CLAUDE PEPPER, A U.S. REPRESENTATIVE FROM FLORIDA

Congressman PEPPER. Mr. Chairman and members of the committee, I thank you very much for your kind words of welcome and for the privilege of being here before this distinguished committee. You are to be commended for the lead in trying to provide needed health care for the people of America, in this instance with emphasis upon long-term care.

Mr. Chairman, I have a prepared statement that I would like to insert for the record, and I will summarize it for you as best I can.

I am very grateful that I can come back here to this distinguished forum to discuss a subject which first commanded my interest in 1938 when I, too, had the privilege of being a member of the Senate.

The Honorable Robert Wagner of New York introduced the first bill on this subject that I know of having been introduced in the Congress. It provided a system of national health insurance. Congress did nothing about it.

Five years later, in 1943, I became concerned about the fact that 4 million young Americans of draft age were rejected from the draft in time of war because of mental or physical deficiencies. I thought that was a shocking commentary on our country.

So, I introduced in the Senate a resolution to set up a select committee to make a study of why so many young men of that critical age were not able to serve their country in time of war. It became known as the Wartime Health and Education Committee. For 3 years we made a study of the subject of education and health in America.

At the end of our study in 1946, because I was chairman of that committee, I introduced a resolution that provided a comprehensive health care program—basically, what we have done since that time. It contemplated the National Institutes of Health, which we now have and which we have made much progress on. It contemplated setting up hospital facilities with Federal aid.

It contemplated many other advances in the field of health, but at the same time, it was not approved either by the Congress of the United States.

In 1945, President Harry Truman sent to the Congress a special message asking for a comprehensive program similar to what my committee had proposed for the American people previously. While it attracted some attention and some discussion, at that time any such proposal was regarded as what they called "socialized medicine," which intimated that it was a first cousin at least of Communism. And anybody who embraced it had questionable ideas about patriotism in America.

Well, Congress didn't do anything about any of these recommendations until 1965. That year was a great year, as I believe this one is also, Mr. Chairman and members of the committee, for the accomplishment of meaningful reform in the area of health care for the American people.

These periods come along. There is a time for everything, the Bible says; and I believe this is the time in the Congress of the United States to adopt some meaningful measures that will provide needed health care for the American people.

So, in 1965, we created Medicare. We know that that provided hospitalization up to 60 days for the elderly; it also enabled older people to consult a physician and provided that the Government would pay 80 percent of the approved fees of the physician that they consulted.

It didn't do anything in the field of nursing home care for anybody except the poor, and it didn't do anything in the field of long-term care, which is still a missing part of the American system. But it made a very creditable beginning.

At the same time, we adopted legislation setting up Medicaid for the very poor—people who had very limited assets; and care under that program is more or less comprehensive in character. There are nearly a million people today in the nursing homes of America who are maintained there by the Medicaid system; and we made some enlargement in that system a little bit ago in the so-called "Catastrophic Bill."

Now comes the year 1988. That catastrophic bill has passed the Senate and the House, and we will have it up before the Rules Committee in the House on the 1st of June and before the House on the 2nd of June. What does that legislation do?

It extends hospitalization throughout the whole year if necessary and proper—365 days. It provides also that you don't have to pay but one deductible each year. As it is now, every time you go to the hospital, in each benefit period you have to pay $540.

As a matter of fact, you will remember that, when we adopted the Medicare legislation in 1965, I think the deductibles was only $40 or $50; it was just enough we thought to keep people from sponging on the system.

The catastrophic bill that is coming up before the House on June 2 makes a little bit of an advance in trying to meet the critical problem of paying for prescription drugs. America's elderly people have to pay about $11 billion a year today for prescription drugs, and we in our conference have finally agreed on some assistance to the elderly in getting the critical prescription drugs that they need.

So, all of that is to the good. We have made a commendable beginning. But we have also had 23 years of experience since we adopted Medicare and Medicaid 1965. We know what needs to change.

We have found that trying to cope with the high cost of health care is a problem not just of people in the lower income brackets. People may be just a little above the eligibility level for Medicaid and not qualify for its benefits.

I had two cases before my committee a little bit ago to show how directly these problems affect the middle class people of America.

There was a man 83 years old; he had a wife of 55 years. He wrote me from Maine that he couldn't appear before our committee for the hearing on this subject, but he would like to tell us his experience. He said, my wife developed Alzheimer's Disease. I had to put her in a nursing home. Then, I had a stroke; and then, shortly after that, he said, I had to have one of my legs amputated. Things went from bad to worse.

He said, now, Mr. Pepper, I am nearing desperation. My wife is still in the nursing home. I have all these handicaps that I have told you about, and we have almost exhausted our savings of $160,000. Now, how many Americans have $160,000 in savings?

I had one other man—a fellow named Howard—from Maryland who appeared personally before our committee. He said, I was 58 years old, I had a good job. My wife and I had a satisfactory home. I had four health insurance policies, and we had $140,000 in liquid assets. I wasn't afraid of the future; I thought I was able to beat any crisis that might come.

Then, he said, one day, the doctor told me—the same information I got in 1977—your wife has cancer. I had to put her in a nursing home. Then, shortly after that, I had a stroke. Shortly after that, I was trying to drive, and I had a bad automobile accident; and things went from bad to worse.

All of my four health insurance policies yield me a total of $96 a month in aid in paying these bills. He said, Mr. Pepper, I am desperate. We have almost used up our savings of $140,000.

We had a hearing not very long ago where we had six elderly women testifying before our committee. At a time when catastrophic illness struck their respective families, every one of the heads of their families had good jobs. They had money in the bank. They owned a home; they had some health insurance. They thought they were pretty safe for the future.

Then catastrophic illness struck. First went the savings; other liquid assets followed. Finally, the last thing to go was the home. I will never forget when one of those women, with tears streaming down her cheeks, said, finally, there wasn't anything else to do except to sell our home. But she said, I dared not tell my husband—who was in a nursing home—that we had to sell our home to keep him in a nursing home. It would have broken his heart.

A million people a year in America become destitute trying to meet the costs of catastrophic illness. That is the problem that we are facing in America today, and that is what we are addressing ourselves to in our respective pieces of legislation.

Now, my bill, which is shared by the distinguished chairman of the Aging Committee in the House, the Honorable Edward Roybal, provides long-term home care. We would like very much to have gotten into the area of nursing homes, and I commend you upon having included that in your bill.

Maybe in conference, we can later work out a joint program that will be satisfactory to us all; but we have concentrated on long-term home care. And our long-term home care bill, we think, will serve not only the elderly who are so deserving of it, but all the other people in America who have long-term illness, including children.

When we first began to consider this matter, we only concerned ourselves with the elderly. And then we were informed that there were at least 200,000 children that also had long-term illness.

And there were many among that group covered by Medicaid and the people covered by Medicare who had long-term illness of a critical nature, like Alzheimer's disease. There are 3 million people, as you know, in America who have Alzheimer's disease. There are 5 million people who have heart trouble. At least a half a million people have Parkinson's disease. There are half a million people who are disabled because of accidents and the like.

And now, I don't know how many million there are who are the victims of this terrible AIDS disease that has come to curse us in our country. But there are millions who suffer from these tragic illnesses, and that is the nature of the problem that is facing us out there.

That is the reason that, in our bill H.R. 3436, we included all the people who are chronically ill—men, women, and children.

Last year in San Francisco, I was holding a hearing. I had a group of mothers sitting before me, each one with a little boy or girl in her arms. I shall never forget the one who sat over here at the end, a beautiful little girl who had a peculiar illness that caused her all of a sudden just to stop breathing; and in 3 or 4 or 5 minutes, she would be dead if somebody didn't do something to resuscitate her.

So, the mother told of the ordeal she had had trying to carry on her other duties, trying to provide a living, and look after that little child who required such constancy of care.

A little bit ago, my niece from Fort Lauderdale, FL called me up on the phone, and said a lady friend of hers from Fort Lauderdale had called her that day. She said, my father and I live together in our family home. I work to support the family. She said, my father has Alzheimer's disease, but heretofore I have been able to take care of him by being home overnight and being home at lunch in the daytime.

She said, now, his illness has progressed to the point of disability, which requires somebody to be right beside him all the time. She said, what am I going to do? If I quit work, then there is nobody to support the family. I don't have the money to hire somebody to stay there with my father all of the time when I am not there.

She said, I don't have the money to put my father in a nursing home. I wish you would ask your uncle when he thinks some legislation is going to be passed by the Congress that will give me some help.

We regard that as a typical case.

I asked those mothers in San Francisco: Are you getting any Federal assistance in trying to take care of these children who have long-term disabilities? One said, no, we are not getting any Federal help. The only assistance we are getting is from the State of California. That is of help to us; I don't know what we would do without it. But, she said, we are having a terrible time trying to make it caring for these children.

Mr. George Miller, a member of the House from California, Chairman of the Select Committee on Children, is one of the strongest supporters of our bill because it does include children. We have 120 organizations-children's organizations, women's organizations, labor organizations, elderly organizations, all kinds of organizations—in this country concerned about providing health care for the people who have long-term illness. They have pledged their support of our bill.

Now, Mr. Chairman, there is a little difference between your bill and ours. We do not include nursing homes in our bill; you do not include children in your bill. You do not include those between the age of eligibility for Medicare and those who are eligible for Medicaid. We do because we call them people who are chronically ill, and we include all in that category.

Now, our bill is before the House. There is going to be some attack upon it by the Chairman of the Ways and Means Committee, and here is how the bill happens to come before the House in the form that it does at the present time.

We were having a meeting with the speaker and the Chairman of the Ways and Means Committee and Chairman of the Energy and Commerce Committee when we were considering the catastrophic bill. I contemplated at that time when the bill was first before the House offering my bill as an amendment to the catastrophic bill.

But my bill would impose a new tax—as does yours—of around $30 billion over a period of 5 years by levying a 1.45 percent tax on all incomes above $45,000 a year. The President having indicated, as he did, that he'd oppose any bills with new taxation of any considerable amount, it became obvious that if I put an amendment on the catastrophic bill which they thought the House would adopt, it would make it more likely—if not assured—that the President would veto the catastrophic bill.

The catastrophic bill does not provide all of the services that should be provided, but I am for it. I supported it when it was before the House in the first instance. I didn't want to see it vetoed; I wanted to see it become the law of the land because it makes a very meaningful contribution to the health problems in our country.

So, at that conference with the Speaker and with the chairmen of the committees and other members concerned about this subject present, the Speaker said, Claude, you have been very decent about this thing. I know you have been an advocate of this kind of legislation for a long, long time, and you are very concerned about it. And I appreciate your willingness to defer introducing your bill as an amendment to the catastrophic bill.

He said, now, Claude, if your bill were introduced as a separate bill, to what committee would it go? Mr. Rostenkowski spoke up and said it would go to the Ways and Means Committee; and the Speaker said, Dan, then you could report out Claude's bill to the House; he could get a separate vote on his bill, and he wouldn't jeopardize the catastrophic bill by offering it as an amendment to that bill.

Mr. Rostenkowski said, Mr. Speaker, I don't think my committee would report out the bill. Well, the Speaker said, if Claude is willing to defer offering his amendment to the catastrophic bill, I will see to it that you get a vehicle upon which it can go to the floor.

The bill that we have now is the vehicle that the Speaker and we have chosen. I thought it was pursuant to a general understanding—at least many understand it the same way that I do. Anyway, they said there have been no hearings upon our bill.

As Senator Durenberger said here a few minutes ago, this committee itself has had numerous hearings over the years. Many other committees of the Senate, many committees of the House, our Aging Committee and your Aging Committee, my Select Committee on Health and Long-Term Care—a subcommittee of the Select Committee on Aging—have had scores of hearings.

This subject has been studied in great detail by the Congressional Budget Office, which has come out with a favorable study of the cost aspects of the thing that you and I are talking about—long-term care for the people.

And so, we are not talking about something that we don't have knowledge of. I think we are talking about something of which we have great knowledge, and we have great knowledge of the need.

Now, Mr. Chairman, I would like to say that we have had a poll done by Lou Harris on the public reaction to our pieces of legislation; and I would like, if I may, to offer for the record the summary of the Lou Harris poll.

The gist of it is, over 80 percent of the people—Democrats, Republicans, people who voted for President Reagan, young people, middle-aged people, old people—support our bill, H.R. 3436.

In addition to that, Mr. Harris finds, over 70 percent, of the people—the same groups, Democrats, Republicans, people who voted for President Reagan, young people, middle-aged people, old people, and even the people who would pay the tax—people who make over $50,000 a year, as we do—are strong supporters of the bill.

So, public opinion wants us to enact legislation in this Congress that will give them the protection that we should long ago have provided for them.

Mr. Chairman, I think I will just say one other thing.

The Congressional Budget Office has made—as I said—a prolonged and careful study of the cost part of our bill. Our bill does not require the people who receive the benefits to make any payment, as yours does with respect to nursing home care. But we do provide protection against people coming into the program who can care for their own families by requiring a county agency to make a careful study of every applicant's situation, to determine whether or not that applicant is entitled to the benefit of our program.

So, we don't want to eliminate the responsibility that the family should discharge to take care of its long-term ill when it is able to do so.

The Congressional Budget Office tells us that our bill, by taking revenue from 1.45 percent tax on income above $45,000, will yield somewhere around $34 to $35 billion over the next 5 years. The cost of our program is estimated by the Congressional Budget Office to be about $30 billion, so there will be a surplus.

There will be no year under our bill in which the cost will exceed the amount of the revenue derived from the tax that we impose, and we specifically provide in strict language in the bill that there shall be no expenditure except from funds derived from the tax that is levied in this bill itself.

So, we are not jeopardizing the deficit, and we are not jeopardizing the debt or adding to it either. What we have tried to do is to find a way by which, without hurting anybody, we will be able to help millions of men, women, and children in America who have catastrophic illness, who have long-term illness, and who desperately need help.

So, Mr. Chairman, my staff has had pleasant contact with your staff, and we would like to work with you in the future. The important thing is—I think—while the iron is hot, while the time is right, while the people are for it, for us to get together to do something that we should have done long ago. At long last, this year, we can give the American people the sort of health care they need and deserve so much,

I thank you very much for the privilege of being with you.

Senator **Mitchell**. Senator Pepper, thank you very much for a very powerful, eloquent, and informative statement. Each of us in our own States have experienced the same examples that you have cited here in parts of the country which you have traveled.

I know in Maine, as I have traveled throughout my State, I have met people who have not only faced but endured financial devastation as a result of illness that has caused the need for long-term care to be created. And it just isn't right that American families—whether in Maine or in Florida or any place else—should have to go through what so many American families have had to go through.

And I hope that working on this subject—your bill, my bill, and a variety of other suggestions—that we can come up with an answer to this. I don't suggest my bill is the perfect or the only answer. It is an effort to stimulate debate.

You are right. There are differences between our bills, but they have the same objective; they have the same concern, and that is to see to it that no American family has to go through what millions now must endure when they face the financial devastation of long-term care.

We are honored by your presence. We are informed by your testimony, and we are inspired by your life really. And we look forward to working with you on this.

Congressman PEPPER. Thank you very much, Senator. I am very grateful to you for the opportunity of being here with you today.

Senator MITCHELL. Senator Packwood, do you have any questions?

Senator PACKWOOD. No questions, Mr. Chairman.

Senator MITCHELL. Senator Baucus.

Senator BAUCUS. Senator, I am just curious what you think the priorities should be as we move into long-term care. What I am getting at is this. When we set up Medicare, we started with acute hospital care and with some Part B coverage. Then, we have extended Medicare coverage to dialysis programs, respite care, some home health care, and whatnot.

Now, as we move down the road and start to enact long-term health care—among the various areas of respite care, nursing home coverage, home health care—I am wondering what you think the priorities should be of the core beginning of long-term health care.

What is most important? I know your bill basically covers home health. Senator Mitchell covers nursing homes and respite care, too. But based upon your experience, what should the priorities be in establishing the core area as we begin to develop a good long-term health care program?

Congressman PEPPER. Senator, I had a grave concern as to whether to try to find some way to include nursing home care in our bill; but we finally concluded that it was a little bit too much to bite off at one time. It will cost about $30 billion to provide the services that we contemplate providing to the people.

We thought we would move into the nursing home question a little bit later, after we have had a little more experience with the home care program. But we all know the old saying, "Home Sweet Home."

Most people, particularly the elderly, don't want to go in a nursing home if they can help it. My sister was in the hospital in Fort Lauderdale, Florida with another lady. My sister went out a little bit and came back; and when she returned to the room, the other lady was crying like her heart would break. My sister said, what is the matter? She said, while you were out, my daughter came in and told me she was going to put me in a nursing home. I have been after the doctor to get him to promise to get me out.

My dear mother told me many times, son, don't ever let them put me in a nursing home. So, people prefer to be in their own homes if they can get substantially the care that they have to have. Now, some will have to go to the nursing home eventually, but a smaller number.

Furthermore, we were very much influenced by the experience that the State of New York is having right now. They have determined to use Medicaid for home care rather than putting all of the recipients in a nursing home. As you know, there are about 1 million people in nursing homes who are put there and kept there by the Medicaid program.

In New York they are finding out, at a great deal of saving, they can put these people in homes and give them care in the home and save putting them in the nursing home.

So, the experience that they are having and other experience that has come to our knowledge induced us to start off at the beginning now with an adequate home care program for all the people—not just the elderly; and you know my dedication to them.

Not just the elderly, but also children—200,000 of whom we estimate need help in the home for long-term care.

So, that is the reason we chose to make home care the emphasis of our bill.

Senator **BAUCUS**. Thank you very much.

Senator **MITCHELL**. Senator Pepper, thank you very much. We do appreciate it. We look forward to working with you.

Congressman **PEPPER**. Thank you very much, Mr. Chairman. I am very grateful.

[The prepared statement of Congressman Pepper and related information appear in the appendix.]

Senator **MITCHELL**. Our next witness is Hon. Hal Daub, U.S. Representative from Nebraska. As Congressman Daub is taking his seat, I would like to call on Senator Chafee, who has joined us. Senator Chafee, welcome.

STATEMENT OF HON. JOHN H. CHAFEE, A U.S. SENATOR FROM RHODE ISLAND

Senator **CHAFEE**. Thank you very much, Mr. Chairman. Again, I want to commend you for holding these hearings. In my State, I have found from long experience with the elderly that their two greatest concerns are the high cost of prescription drugs and the costs of long-term care.

We have dealt now with the high cost of prescription drugs in the catastrophic legislation that we agreed on in conference, and now we are undertaking the challenge of meeting the long-term care needs of our elderly. This is something I am intensely interested in, Mr. Chairman; and I think the witnesses you have are excellent.

I was glad to hear Senator Pepper; and of course, I am a cosponsor of your legislation, Mr. Chairman. So, I hope that from this, we can proceed on and make some real achievements on taking care of the elderly and the long-term care costs that they encounter so drastically and so frighteningly so often. Thank you, Mr. Chairman.

Senator **Mitchell.** Thank you, Senator Chafee. I would like to just make a comment on Senator Baucus' point because I think it is well taken about the difficulty of establishing priorities.

I have become convinced as a result of the studies that we have made in this area that it is necessary to have the comprehensive range of services reimbursable in some form because what has happened in our society is that medical care decisions are increasingly based upon reimbursement policies.

The type, level, and cost of service that an individual receives are increasingly based upon which type of service is reimbursable, rather than what is the most appropriate level of service suitable for that individual.

The result is increasingly higher cost than would otherwise be the case. People are right now in acute care beds in hospitals who could be in nursing homes, a lower level and less expensive type care; but they can't get into nursing homes because there are many people in nursing homes who would be better off at home but are in the nursing home because that is reimbursable, whereas home care isn't.

And so, you have a ripple effect in which literally hundreds of thousands—perhaps millions—of individuals are receiving care that is actually more expensive than they prefer and than would be better for them because the decisions are based upon reimbursement as opposed to the individual need.

That is why I became convinced that the only feasible policy in long-term care—and I think we have to increasingly spread it throughout the entire system—is to provide the broadest range of service and then control the cost by utilization controls, either in terms of exclusionary period as in my bill or deductible or copayment or something along those lines.

Senator **Baucus.** I just think the question of priorities is one that we are going to have to address.

Senator **Mitchell.** Yes, we are.

Senator **Baucus.** I think it goes to the core, if you will, of the final decision we make here.

Senator **Mitchell.** Yes.

Senator **Chafee.** Mr. Chairman, you have given a powerful endorsement of S. 1673, my home and community care legislation—— (Laughter)

Which provides Medicaid coverage for the developmentally disabled in their homes, rather than only paying for it in institutions. The whole term ""Medicaid" means they get paid when they are in a medical setting, when they ought to be reimbursed when they are at home.

I hope we can move that legislation out of this committee. I believe you are a cosponsor; if not, we have an opportunity for you to become so. (Laughter)

Senator **Mitchell.** Although that is not the subject of this hearing, Senator Chafee, I think any good cause ought to be plugged at every opportunity. (Laughter)

Senator **Chafee**. Thank you. I will bear that in mind.

Senator **Mitchell**. Welcome, Congressman. We look forward to hearing from you.

STATEMENT OF HON. HAL DAUB, A U.S. REPRESENTATIVE FROM NEBRASKA

Congressman **Daub**. Thank you. I won't take long, Mr. Chairman. I do appreciate the opportunity to be with you and members of your Health Subcommittee, and I appreciate the opportunity to participate today in this discussion of what can only be called the "American long-term health care crisis."

Surely, all present will agree that few issues are more deserving of Congress' attention than the skyrocketing, bank breaking costs of long-term care. Recent estimates indicate that over 80 percent of health care expenses incurred by the elderly relate directly to long-term care and to, specifically, nursing home costs.

Further, it has been shown that, while eight out of ten senior citizens are protected from acute hospital-related health care costs, a full nine out of ten have no protection from long-term care expenses. This deplorable situation is unnecessary, as I also believe it is sad.

Older Americans should not—indeed must not—be forced to make that last terrible choice between bankruptcy and ignominious death. And so, as responsible legislators, we are faced with a dilemma: How are we going to address the problem while preserving sound fiscal policy?

To date, most members of Congress have responded to this challenge with proposals of entitlement expansions funded by tax increases. In fact, additions to Medicare and increased taxation have been advocated by some as the sole means of amending our nation's health care inadequacies.

A case in point is the acute illness cost containment bill recently issued by the House/Senate Catastrophic Conference Committee. Here, Mr. Chairman, is legislation which promises to cost at least $45 billion dollars by 1992, burden the many with outlandish new taxes, and help the few, all in the interest of providing seniors with benefits they in most cases—as I just outlined—already have, and in many cases simply could do without.

Now is not the time for the reckless expansion of entitlement programs. In my estimation, of course, there should never be such a time. I am willing to agree that the Federal Government must play a substantial role in the formulation of a viable, long-term care cost solution; but I propose that there is a resource out there which has been ignored far too often during our deliberations over long-term care policy; and that is the private sector.

Admittedly, legitimate studies have assigned to the private sector only a limited long-term care domain; but the fact remains that the health care underwriting industry is an increasingly advantageous position to help fill the void which currently exists across the range of approaches—the long-term care cost management.

I and my Ways and Means Health Subcommittee colleague, Brian Donnelly, introduced some time ago a bill, H.R. 3900, which seeks effectively to apply the best of what both the Federal Government and the private sector have to offer.

Essentially, my bill is divided into three sections. The first section adjusts the machinery of our current health care entitlement program and provides for Medicare coverage of home health services and nursing home care costs.

This limited expansion is entirely self-financing. It demands no premiums from eligible individuals and calls for beneficiary participation in the handling of long-term care costs through a carefully structured schedule of deductibles. I might say briefly that that would be if your first dollar of income in retirement eligible for Medicare is $1 and up to $10,000.

The first $5,000 is a deductible paid by the beneficiary, and the remaining would be paid by what we establish as a—I guess we will have to call it a Part D now since there will be a Part C being established, a new trust fund under the current catastrophic bill.

Then, from $10,000 to $20,000, there would be a 70 percent deductible; from $20,000 to $30,000 an 80 percent deductible; and from the $30,000 figure upward, 90 percent. You have to wait until you get to the third part of our bill to understand that we seek to lessen the blow of the deductible by the private sector alternatives that we offer.

Section 2 of our bill establishes tax incentives designed to encourage the working age population to look to the variety of private market insurance products and purchase independent long-term care insurance plans. Prominent among these incentives are the tax-free conversions of individual retirement accounts and cash value loaded life insurance policies to private long-term care plan premium funds.

The purpose essentially is to make that conversion a tax free occurrence, that is, what would be otherwise the taxable consequence of a withdrawal from an IRA, a fixed or defined plan, a profit sharing plan, and/or the conversion of inside buildup, which we call the "cash surrender value" of whole life policies, could be laid over onto the purchase of a premium, if, in fact, that was by definition a life care, a 36-month, or a 3-year or a 5-year, 60-month long-term home health plus nursing home care coverage.

And I would actually find that we could mandate that there must be a cash surrender value inside of that conversion in the event you were 68 years old or 72, got hit by a truck, and never used your life care long-term policy, the inside buildup, the cash surrender value, or what was otherwise deferred in its former life would still have that same attraction.

So, during your working years, when you were encouraged to build the IRA or build the cash surrender value and then converted the tax potential of that to a long-term care plan, the incidence of which would be tax-free, that in the event you never used your long-term plan, it would still have that potential of being an estate builder and being passed on to your surviving beneficiary.

That could be defined in Section 2 if it were to be elaborated upon.

Finally, my legislation motivates employers to offer long-term health care plans to their employees during their working years in the workplace. Such plans would be subject to a Federal tax treatment similar to that applied to the current private pension and general retirement programs.

I will digress from my statement to elaborate briefly that in the Kerr Mills history, which I know each of you on the committee is familiar with—some 30 years ago—we established by using the Tax Code the opportunity for employers to provide fully funded or partially funded retirement plans. That portion of which was from the company was tax deductible as an expense of doing business.

When you left your workplace and entered into your older years, you had that retirement benefit and much, if not all of it over the last 30 years, has been tax induced. But we do not include in that deductible portion the health care portion that may be offered as a deductible part of an overall picture of retirement.

So, really what we should struggle with is to change the definition of "retirement" to "retirement including health care costs" and utilize the workplace and the incentives that can come from a tax-induced deduction or expense to provide a greater benefit, not just to retire in Sun City and/or to take trips, but indeed to also contemplate that expense of home health and nursing home care that could be provided for earlier, much less expensively, and lower the burden that we may ultimately then have to face in more federally funded or transfer payment types of programs, some of which have been testified to here today.

So, it is through a combination of direct Government support and private sector stimulation that my bill—our bill, the Daub-Donnelly bill—would address older America's most pressing concerns.

I have placed a premium on balance and fairness, and I have above all sought to provide the means by which an ever-growing elderly population can avoid the financial and emotional devastation of long-term health care costs.

Certainly, there remain imperfections in this bill, H.R. 3900; but the bill's major strength lies in its conceptual recognition of the necessity of a marriage between Federal entitlement and the private sector. And it is in denying this union that bills such as Senator Pepper's, H.R. 3436, falls short of achieving a last word health costs solution.

Please understand. What disturbs me is not so much the method whereby Senator Pepper has chosen to finance his home health care benefit. Indeed, our own bill makes limited adjustments to the hospital insurance portion of the FICA tax, that is, utilizing the 1.45 percent and capping it at $50,000.

Rather, it is the construction of the benefit itself where I take issue. H.R. 3436 would establish a massive new home health care benefit program whose ambiguities render it virtually unworkable while ignoring both nursing home care costs and arguably the true health care catastrophic problem in America today, and the private sector, a very valuable resource, to a growing older population.

Above all, this legislation furthers the current trend of health care socialization, a phenomenon never envisioned, I am quite sure, by Medicare's original designers.

Mr. Chairman, I will submit that the American insurance industry might well be considered an endangered species in the very near future if developments are permitted to proceed at their present pace.

Still, promising measures such as yours, Senator Mitchell, that is S. 2305, recently have begun to receive their much deserved attention. In the distinguished Senator's bill, we witness the implicit recognition that the Federal Government's role is not that of obligatory compensator; it is rather that of beneficial and timely provider.

S. 2305 emphatically asserts that there is ample room here for both the Government and private industry to lend a helping hand to the long-term care cost victim; and the bill promises to deliver where it is most needed, both on the home care front and the nursing home care front.

I applaud Senator Mitchell's efforts, and I hope that Congress can look to his example in future efforts to shape sound, equitable, cost-efficient health care policy.

Mr. Chairman, thank you once again for this opportunity. I am confident that sincere and responsible Congressional action eventually will result in the end a long-term health care cost solution that takes into account not just what we in Government may do, but what the private sector can do to make a much leveler, fairer playing field.

And those who are able to afford their own health care would have the opportunity to do it at the private sector's behest, rather than turning—if they are millionaires—to what the taxpayers could provide.

Senator MITCHELL. Thank you very much, Congressman, for a very thoughtful and forceful statement. Senator Packwood?

Senator PACKWOOD. No questions, Mr. Chairman.

Senator MITCHELL. Any other member have questions for Congressman Daub? (No response)

Thank you very much. We do appreciate your testimony.

Congressman DAUB. Thank you. I am glad to be here.

[The prepared statement of Congressman Daub appears in the appendix.]

Senator MITCHELL. The next witness will be on a panel, including Mr. Robert Ball, the former Commissioner of the Social Security Administration, and Member of the National Commission on Social Security Reform; Mrs. Louise Crooks, President, American Association of Retired Persons; and Mr. Dallas Salisbury, President, Employee Benefit Research Institute.

The previous witnesses, having been Members of Congress, were not subjected to the time limitations accorded other witnesses. You have been witnesses before this committee many times, particularly you, Mr. Ball; so you are familiar with it. However, for the benefit of future witnesses, I will restate the committee's practices briefly.

Witnesses are asked to limit their remarks to 5 minutes in their oral presentation. Your written statement will be included in full in the record.

Following the statements of each panelist, the members of the committee will be permitted to ask questions in the order of their appearance and will be limited to 5 minutes for each round.

I am advised that a vote in the Senate has just begun on a motion to table the Wallop amendment. It is a 15 minute roll call vote; so there will be Senators coming and going as you testify.

To help you in adhering to the time limits, there is a small panel of lights in front of me—one green, one red—they mean the same thing that they mean out on the streets. If the green light is on, you can just keep right on going. When the red light comes on, it means stop. Thank you very much.

Mr. Ball, welcome. As always, we look forward to your advice and counsel.

STATEMENT OF ROBERT M. BALL, FORMER COMMISSIONER OF SOCIAL SECURITY, AND MEMBER, NATIONAL COMMISSION ON SOCIAL SECURITY REFORM, WASHINGTON, DC

Mr. BALL. Thank you, Mr. Chairman. I would like first to congratulate the conferees on the catastrophic agreement. I think it is a great step forward and very important. I know it was difficult to achieve.

All of those of us who have been interested in this subject of long-term care insurance for a long time are greatly encouraged, Mr. Chairman, by your introduction of S. 2305 and your assumption of leadership in bringing about a Federal program in this area.

It is my opinion that your bill thoughtfully addresses the issue and deserves very careful consideration, that it will serve well, as you have suggested, as a basis for consideration both in the private area and as regards a public program.

Mr. Chairman, in the last several months I have reexamined my position on this issue; and as recently as four or five months ago, I had a different view than I do today. I originally favored a comprehensive approach through a Federal insurance program—not completely, of course; there would be copayments and deductibles, but nevertheless, a generally comprehensive approach.

It seemed to me in the last few months that, given the great demands on the Federal Government for new and expanded programs, the dearth of social advance, you might say, of the last 7 years, and the continuing problems of the deficit, that it behooved me, along with others, to think through again what are the highest priority issues in the long-term care field from a public policy standpoint, and what parts of that issue could be reasonably addressed by private insurance.

My conclusion, for the moment, anyway, from a public policy standpoint, there are three areas that are of the greatest importance. The first is having available help to those families that have taken on the responsibility of caring for a disabled person at home, so that a home health care system, along with a respite care benefit, is one very high priority that I think only the Federal Government will adequately perform.

It is very difficult to handle in a private insurance approach, and I suspect it will be done only very partially if left to them.

The second seems to me to preserve the income and assets of those people who have a reasonable likelihood of leaving the nursing home so that that income and assets will help them when they are back in the community.

And third, to preserve the income and assets of those in nursing homes who have in the community a spouse who needs that income and those assets to maintain the level of living that that family has achieved.

Beyond that, there is of course the need for those people who are going to be in nursing homes for a long time to protect their assets for their sons and daughters and other heirs; but it has seemed to me that, if we have to reduce the Federal role somewhere from my original, more comprehensive plan, that is an area of estate protection that perhaps could best be left to private insurance.

Consequently, I have designed the outlines of a plan and financing that is attached to my statement that in effect is a comprehensive home care and respite benefit, a 6 month nursing home benefit, with an extended benefit if there is a spouse in the community. And I have tested this against the discharge data in the 1985 National Health Survey to find out who it is that isn't covered by that kind of a plan.

And what you find out is that the people who are not covered are those who have almost no chance of leaving a nursing home, who will be there the rest of their lives and who do not have a spouse in the community. That is a group that I would encourage strongly to have private insurance, sell to people in their 60s and 70s, of protection for those estates for those who have estates and have assets to protect.

And beyond that, if people who are in nursing homes beyond the six months or beyond the extended benefit time, to have them be in the position where it would be considered all right under a liberalized Medicaid program to use as a first charge the income and assets of such people continued in nursing homes probably for the rest of their lives.

Senator MITCHELL. I am going to have to interrupt. Thank you very much. The three of us will have to go vote. The hearing will be briefly in recess, but will resume upon the return of the first Senator to return, which should be momentarily. Then, we will pick up with Ms. Crooks, and we will go on from there. Thank you very much.

(Whereupon, at 10:48 a.m., a brief recess was held.)

AFTER RECESS (10:59 a.m.)

Senator PACKWOOD. Senator Mitchell has asked me to resume the hearing so that we can move as rapidly as possible. We are going to have a series of other votes, off and on during the morning; and if we were to wait every time until he could get back, we would too delayed. I don't know how far along we were when I left. Who was testifying?

Mr. BALL. I had just finished.

Senator PACKWOOD. All right. Ms. Crooks?

STATEMENT OF LOUISE CROOKS, PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS, WASHINGTON, DC

Ms. CROOKS. Thank you, Senator Packwood. I am Louise Crooks. I am the President of the American Association of retired Persons, and I agree wholeheartedly with you. I wish they had done something about this 50 years ago, but they didn't; and so, it is time to start now.

The debate over catastrophic highlighted the need for comprehensive long-term legislation. Your serious attention to long-term care will spark productive legislation and will begin to move this critical need from a welfare-based system to one base on social insurance.

Our society is already paying the costs of long-term care, but in a way that places inordinate burdens on the victims of chronic illness and their families. The issue for Federal policy is how to spread the burden so that the cost to the any one person will be small, while offering protection and appropriate care to all.

AARP believes that the answer will be found in a social insurance, rather than a welfare approach.

First, I want to stress that the association and its leadership are reluctant to expand long-term care benefits for the elderly without also addressing the needs of younger Americans. These individuals are our children and our grandchildren.

We are as concerned about the burdens being placed on the families of chronically ill children as we are about the burdens being placed on families caring for the frail older relatives. We hope that you will give serious consideration to expanding your proposal to include these younger groups in order to stimulate national debate on this issue.

We should build upon States' wide experience in administering long-term care services by giving them a significant role in the administration of the new program with appropriate Federal oversight.

Both service delivery systems and the profiles of long-term care populations vary widely between and within the States, and States will need to have flexibility to tailor programs to meet their distinctive needs.

The bill language concerning the assessment and case management process needs greater clarification and should incorporate additional consumer protections. For example, it will be critical for case managers to conduct in-person assessments in order to determine individual needs and preferences, to discuss coverage determinations and service options with beneficiaries, and to permit some choice of providers.

We are pleased that the bill encompasses new in-home as well as institutional care services. We would recommend, however, that a broader array of home and community based services should be covered under the bill, including adult day care, transportation, and home delivered meals.

This would give case managers greater flexibility in arranging services to meet individual needs and promote independence. Evidence suggests that providing a broader package of services would not lead to significantly higher costs, provided they are carefully managed.

Additionally, we are concerned that the $500 deductible for home care would serve as a barrier to the use of such services by persons with low and moderate incomes.

Happily, we expect enactment of catastrophic legislation, which will include a modest respite care benefit. Experience gained from this benefit will be helpful in implementing comprehensive long-term legislation.

We are pleased that you have included respite care in your bill. However, we believe respite care should be regularly covered home and community care service rather than a separate benefit. The legislation should simply specify that providing relief to care givers is a legitimate reason for case managers to authorize home care or day care services for beneficiaries who meet the eligibility criteria.

We have very serious reservations about the impact on beneficiaries of the 2-year deductible period for nursing homes. This provision would primarily benefit upper income individuals but do little to protect those with lower and middle incomes.

We cannot forget that the most likely candidate for nursing home care is a nonmarried women aged 80 and with a very low income. Even if one assumes that a substantial majority of the elderly could and would have private insurance, which we think is a very generous assumption, this does not necessarily mean that such policies would provide sufficient protection to prevent most residents from spending down onto Medicaid before the 2-year mark.

Policies typically have a variety of limitations which also reduce the protection they can offer. Moreover, private long-term care insurance is unavailable to those with preexisting conditions and to those age 80 or 85. We should not develop a new public/private long-term care program that ignores those most in need.

If our Nation is to achieve a cost-effective long-term care system which addresses the needs of our most vulnerable citizens, public sector coverage for nursing home care must be comprehensive.

We welcome this serious proposal to reform our Nation's long-term care system, and we look forward to working with you and presenting our views in the future. Thank you.

[The prepared statement of Ms. Crooks appears in the appendix.]

Senator MITCHELL. Thank you, Ms. Crooks. Mr. Salisbury.

STATEMENT OF DALLAS L. SALISBURY, PRESIDENT, EMPLOYEE BENEFIT RESEARCH INSTITUTE, WASHINGTON, DC, ACCOMPANIED BY DEBORAH J. CHOLLET, SENIOR RESEARCH ASSOCIATE

Mr. SALISBURY. Mr. Chairman, it is a pleasure to be here today. I am accompanied by Deborah Chollet, a specialist at the institute on health and long-term care issues.

Among the general population, recognition that neither Medicare nor most private insurance plans cover long-term care has come very slowly; and recent public opinion polls document the fact that many still believe they have coverage in these areas.

Since few people have recognized the likelihood of needing long-term care, most do not plan to save sufficiently to finance care or to budget to purchase insurance. S. 2305 attempts to strike a balance between the desirable and the affordable and a balance between public, private, and individual roles.

As a result of the growing recognition of the possibility of long-term care that comes with an aging population, a growing number of employers are looking to insurance models to help employees finance long-term care; and a growing number are beginning to offer that coverage to their employees.

At the same time, organizations such as the American Association of Retired Persons are actively marketing a program that, based on their own press statements, they feel has the potential of being extremely successful.

In terms of the prospects of future employer growth, there are related issues. New accounting procedures which will require employers to recognize accruing liability for retiree health insurance provided by employers on both the income statement and the balance sheet could influence employers' willingness or ability to assume responsibility for paying long-term care insurance premiums.

Yet, a reallocation of overall employee benefit expenditures could provide capacity. S. 2305 recognizes that potential capacity by providing for the provision of long-term care insurance through cafeteria plans, recognizing the value of choice and the value of economic flexibility.

The limitations in the long-term care insurance policies so far developed reflect insurers' hesitation to commit to long-term care insurance products as a result of insufficient data and, in other cases, uncertainty over present tax law. S. 2305 would provide that certainty requested by many through tax treatment changes, and while not providing the data, in the eyes of many would provide a significant additional incentive for individual companies to create products.

Insurers' tentativeness about entering the long-term care market has been matched by employers' reluctance to institute new benefits or to assume additional health care financing obligations for both workers and retirees. The long-term care insurance being marketed, I again note, by AARP, does imply, however, that there is a potential for progress.

And in most recent press coverage, which was critical of the prospects of private success, AARP itself has underlined the tremendous sales success of its product as indicative of the potential for a private complement to any public sector action.

Your bill has clearly given that balanced approach. The committee faces a very difficult challenge as they confront the complexities of the issue, as the other witnesses so ably noted.

You have articulated, however, probably the clearest central issue. The policy issue we face, I quote "is how to target our limited resources to the elderly that are most in need."

Ms. Crooks has noted that the current deductible approach in your bill has certain difficulties. I would note that, as in many private insurance products today, tying that deductible and that front end to a percentage of income might well respond to many of her concerns while still providing a disincentive to early usage.

Management is critical. We might income-relate the deductible, and we should as well consider other areas of reform, such as retiree medical provided by employers, and such as the preservation of distributions from pension plans, in order to target resources in this area.

Through tax incentives, I underline the Federal Government now encourages a substantial and growing system of pension provision for retirees. That system provides an important part of the income that could pay for long-term care insurance and now, in fact, does help to finance long-term care services.

We commend the committee for undertaking the challenge of restructuring a workable system of long-term care financing in the United States and stand ready to assist the committee through research and data in any way that we can. Thank you very much.

[The prepared statement of Mr. Salisbury appears in the appendix.]

Senator MITCHELL. Thank you very much, Mr. Salisbury, for very informative testimony.

Before going to the questioning, I would like to recognize Senator Daschle, a new and valuable member of the committee. Senator Daschle, welcome.

OPENING STATEMENT OF HON. TOM DASCHLE, A U.S. SENATOR FROM SOUTH DAKOTA

Senator DASCHLE. Thank you, Mr. Chairman. I want to commend you and the subcommittee for your leadership in this area. It has interested me for some time.

I think there are probably three certainties as I look to this issue. The first is that there is a tremendous desire that we address this issue, and there is a need. I think that this committee recognizes that.

The second is, that within the next couple of years, we probably will address this issue. And the third is that, however we address long-term care it is going to be a very expensive project. I look forward to working with you in trying to come up with a comprehensive approach for the least amount of money to benefit the broadest number of people.

I look forward to the hearing today.

Senator MITCHELL. Thank you very much, Senator Daschle. We will now begin the questioning. Ms. Crooks, I am sorry I wasn't here when you read your statement, but I have reviewed portions of the written statement.

We, of course, welcome your testimony. The American Association of Retired Persons is an important voice for the elderly in our society and a very constructive contributor to national policy here, as we have just seen on the catastrophic health care.

I know you disagree on the exclusionary period. I have discussed that with you and other officials of the AARP on many occasions; and as I have told you many times, we welcome any suggestions for a broader benefit. We ask that they be accompanied by recommendations on how to pay for it.

I noted in your written statement the words "We hope to have the opportunity in future hearings to propose financing options which would permit more comprehensive coverage." And I want to tell you that you will have the opportunity to propose further financing. (Laughter)

Ms. CROOKS. Thank you.

Senator MITCHELL. And we look forward to that. As I said, the 2-year exclusionary period is obviously, to some extent, arbitrary. It has two purposes: one to permit a portion of this need to be met by private insurance, and the other to deal with the problem of cost. And we look forward to hearing from you in that regard.

Now, I would like to ask you a specific question on that. One way to reduce the exclusionary period, without increasing the overall cost of the program, would be to institute a sliding scale of copayments based on income for nursing home and home health benefits. What would be your reaction to that? And you may either respond now orally or submit a statement in writing if you would like.

Ms. CROOKS. We will be glad to submit a statement to you.

Senator MITCHELL. All right. Thank you very much.

Now, Mr. Ball, you made a good case for a front-end coverage, and I will have a couple of questions about that in a moment. But what would your reaction be, assuming an exclusionary period, to my question to Ms. Crooks; that is, reducing the exclusionary period without increasing the overall cost by having a sliding scale of copayments based on income?

Mr. BALL. Mr. Chairman, I am concerned about a series of development that are putting more and more costs on middle income and higher income people and making our social insurance approach to the health care field extremely progressive.

Now, "progressive" is a word that most people like, but I would direct your attention to two developments. One is that in the hospital insurance program itself, the relationship between contributions and benefits is already very, very heavy on the person in the middle income compared to lower income people.

Take the $40,000 a year worker. He pays four times as much as the $10,000 a year worker for exactly the same benefit. Now, in the catastrophic bill that has just been added, we have a sliding scale tax that again hits, in retirement, those people who are at the middle level.

Then, in the taxation of Social Security benefits—which I strongly favor, and I favor the catastrophic, too—we have a floor only above which people are taxed on half their benefits. Only about seven percent of the people who get Social Security benefits are taxed.

It seems to me that we could be in danger of losing if we continue in this direction. Let me just add another—the proposal to finance more health benefits by applying the Medicare 1.45 percent in addition above the cap. That means that you are going to finance a broadly based benefit by a tax on about 10 percent of the people.

Senator MITCHELL. I didn't hear in your presentation how you propose to pay for your plan. Maybe you could tell us how you would do that.

Mr. BALL. Mr. Chairman, the two things I prefer, and I put in the plan as my first choice, would be a surtax on the estate and gift tax—which is similar to yours, although I would do it to a somewhat greater extent—and then I propose directly an increase in the deductions from workers' earnings matched by employers—the traditional social insurance way.

Senator MITCHELL. Would you repeat the last portion of that? Neither Senator Packwood nor I understood what you meant. I understood the estate tax, but what was the other part of it?

Mr. BALL. A deduction from workers' earnings matched by the employer of an amount of three-tenths of one percent, which is the traditional way of financing social insurance. You know it as the payroll tax.

Senator PACKWOOD. An increased Social Security tax?

Mr. BALL. Right.

Senator PACKWOOD. All right.

Mr. BALL. Now, that I know is not a very popular proposal on the Hill at this time, but I submit that if the country as a whole—workers as a whole—are going to benefit from a social insurance proposal, it is not unreasonable to have the deductions made from workers' pay matched by their employer. That is a good, traditional way of doing it.

Now, I was really saying that in many, many ways, we are beginning to finance what were broadly spread and shared costs more and more and more on the middle income person. And although I have favored the things that have happened so far, I am raising a question whether pursuing this again and again we are not going back to the well a little too often.

That is a long way of saying that I have a lot of reluctance about an income based deductible in the health system.

Senator MITCHELL. One of the goals of my bill is to move away from a reliance on Medicaid as the primer payer for nursing home care now. I have structured my bill so that Medicare and private insurance would take over the role now assumed to some extent; obviously, there would still be some Medicaid there.

Your proposal relies on Medicaid after the up-front Medicare time has passed. Wouldn't we still, under your proposal, face the same situation we now face with the Medicaid spend-down, only delayed for 6 months?

Mr. BALL. I don't think so, Senator. I, too, rely on private insurance coming in and filling a major gap. The difference is that private insurance is not quite as crucial to my plan as it is to yours.

In the 2-year up-front deductible, if private insurance fails to provide coverage for a large number of people, which I suspect it will, there are very few who can survive that 2-year deductible.

So, before they get any social insurance at all, they will start to have to spend down and will have the income levels of their spouses lowered; whereas, if you put it at the end, then the failure of private insurance to cover a large part—and I hope they cover just as much as people have assets and want to cover it—the failure there is that you have failed to protect the heirs of individuals who no longer have a spouse—we are talking mostly about sons and daughters—and people who have failed to buy private insurance.

The loss there is a true loss, but it is a loss to the sons and daughters; and the individuals have already entered a nursing home without a means test, without a spend-down, those who stay beyond 6 months—a smaller and smaller group. Then, for them, you would use the income and assets, liberalized—I suggested raising the income allowance to $100 and asset protection to $5,000—you would use that before Medicaid kicked in. I agree.

And it is not a complete solution. There is a major role for private insurance. In both our approaches, Senator, there is a residual role for Medicaid that could be quite large, depending on how successful private insurance is.

Senator MITCHELL. Thank you very much, Mr. Ball. Senator Packwood.

Senator PACKWOOD. Ms. Crooks, tell me about the long-term care policy that AARP sells that Mr. Salisbury referred to.

Ms. CROOKS. I don't know that I can explain that in detail to you right now, but we have had several long-term policies. We have a new one now, and this is still in the pilot stage. And we are trying to test the waters, as you might say, to see how many people can actually afford long-term care.

This is the big problem. So many of these long-term care insurance policies are ones that many people, first of all, cannot afford. People 70 and 75 and 80 years of age can't afford them because it is too high a policy.

Senator PACKWOOD. Is AARP trying to develop them for those who can afford them? I am curious what you are up to.

Ms. CROOKS. We are trying very hard to find a policy that would cover these people that they could afford. Of course, as you know, the more people we get into the program, the less it would cost.

Now, one thing, too, that we run up against is that many insurance policies will not cover previous illnesses. If you had some illness or another, they will not cover that illness. They will not insure you. People 80 and 85 are not insurable in many instances.

So, we are still working on this policy to see if we can come up with a policy that people could afford and that people could participate in. At the present time, I don't think that we have the total solution. No.

Senator PACKWOOD. Mr. Salisbury, you referred to uncertainty in the tax laws as a deterrent for the moment to employer provided benefits. What is the uncertainty?

Mr. SALISBURY. There are currently ruling requests, for example, that Senator Mitchell has referred to in his written documents, over whether or not reserves related to long-term care insurance policies would receive the same tax treatment as life insurance reserves.

And until the Internal Revenue Service makes a ruling on that, many carriers are unwilling to move forward on any aggressive basis.

Beyond uncertainty, there is an issue which this legislation and other bills deal with, which is the question of whether or not long-term care insurance premium payments could receive the same tax treatment as health insurance premium payments, which is not an issue of uncertainty but change.

Senator PACKWOOD. They would receive them now if they were for health benefits. The question is: Is long-term care a health benefit?

Mr. SALISBURY. The question is: Which long-term care provisions, if any, fall within the definition of health. Yes.

Senator PACKWOOD. So, at the moment, you would have two problems. One, it is not deductible from the employer's standpoint and exempt from income—well, probably deductible from the employer's standpoint as a current employee expense; it may be taxable as income to the employee, unless it is health benefits.

Mr. SALISBURY. Right.

Senator PACKWOOD. So, you need that certainty. Second, the insurance companies want to make sure that they can have the reserves treated like life insurance reserves.

Mr. SALISBURY. Right.

Senator PACKWOOD. If you had those two, how much of a void do you think could rationally be filled by employer provided insurance?

Mr. SALISBURY. If you were to add a third, many of the companies are more willing to make a statement; and that third would be the provision that would allow for long-term care insurance to be included in a cafeteria plan, which is a provision in S. 2305, such that—whether it be employer or employee dollars—they could be used on a pretax payment of the insurance premiums.

If one looks at the prospect, therefore, of that type of change, plus a change to a treatment similar to health insurance for tax purposes, and one simply looks at the degree to which health insurance is currently available to full-time workers in firms of more than 250 workers, which is in excess of 95 percent of those workers, one could hypothesize that that same market potential is there relatively quickly for long-term care insurance.

Senator PACKWOOD. Say that again. That it is not there?

Mr. SALISBURY. I said that is your potential market place fairly fast. Based on the relatively low pricing that has been described by legislative proposals and others, if you were to include the full group of workers at all ages in the insurance pool—the point being made by Ms. Crooks so effectively.

Senator PACKWOOD. Thank you, Mr. Chairman.

Senator MITCHELL. Thank you, Senator Packwood. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman. I am deeply concerned about the cost that the elderly might confront in connection with long-term care. I was one of the principal sponsors of the catastrophic legislation, especially the prescription drug benefit, which was adopted on the Senate floor, and then we adopted it in the conference, at which I was a conferee.

Yesterday, we completed here in the Finance Committee the third day of hearings on the health care needs of our children in the United States, and I must say that testimony was devastating. The children in America are the most impoverished single segment of our society.

I have heard Pat Moynihan say this, and I am not prepared to dispute it, that we are the first civilization in history in which we treat the children in the worst possible fashion of all the groups. Of the children, 20 percent have no health insurance, and that percentage is growing every year. Ten to fifteen percent of all U.S. children suffer from chronic health impairments.

So, my question to you is this—and you touched on this, Ms. Crooks—and I was glad to hear your testimony on this point. Is it right for us to proceed in this segmented fashion of caring for one group, which should be cared for and I support care for—that is not the matter before the committee here—but is that the correct way to proceed?

In proceeding, for instance, with the legislation that has been proposed by Senator Pepper and others, you would take from our society probably $7 billion a year; and yet, it does nothing for children. I am going to ask each member of the panel to please answer this: Is this the correct way to proceed for the best interests of America, to proceed in this fragmented fashion? We take care of this group, but not the other group.

What do you say to that, Mr. Ball?

Mr. BALL. I would much prefer that, if it were a feasible thing to accomplish, to have a comprehensive plan at all age groups, certainly. I would like to say, though, Senator Chafee, that I believe it is wrong to think of the long-term care proposals that we have under consideration as being primarily or certainly not exclusively an elderly benefit.

Senator CHAFEE. I agree with that, and that testimony has been made. In your testimony, you spoke about the children who are supporting their parents.

Mr. BALL. Right. I mean, Senator Pepper's bill includes other people, but the people really at risk are the middle aged people who will either have to pay nursing home costs for their parents or two-career couples having to take a parent into the home—time, attention, money, away from children.

It is a family situation that we are trying to deal with here, I don't think even primarily a benefit for the elderly.

Senator CHAFEE. That is an excellent point, but when I use the term "children," I am using the term of those under 21, under 18 in our society; whereas when you use the term "children," you are talking about young adults who are caring for their parents.

Mr. BALL. No, I would say the whole family is affected by a situation. If you have to bring elderly parents into a home or pay for them in a nursing home, those children get less attention and less money if you do that.

Now, that is not to say that I have any disagreement with your point whatsoever. If I had to set priorities, I would say maybe the highest priority of all is the 37 million people who are uninsured completely in this country and another 13 to 20 million whose insurance is incomplete; and the fact that there are 20 percent of our children in that group is a national disgrace.

I would put the highest priority of all on comprehensive care for a health plan that covered the acute care costs of these other groups; but I don't like to have to choose that way. It seems to me we want to do both.

Senator CHAFEE. None of us want to choose. I just think we have to look at the whole structure of our medical delivery system in the country with these 37 million people who are uninsured. I was so pleased to hear you, Ms. Crooks, representing the AARP, discuss that very point and make it clear that you are concerned about the children in our society as well.

Ms. CROOKS. After all, Senator Chafee, we are the parents and the grandparents of the next two generations, that is, our group is. And we are very interested in the disabled children. On any given day, they say there are 7 million care givers in the home, and many of these care givers are giving care to disabled children.

Therefore, we are very interested to include disabled children; and we think that it is very important.

Mr. **Salisbury**. Senator, I would describe it as more potentially dangerous versus just unwise in that it allows the process not to be brought together in terms of how much all of it taken together would cost.

We have a report coming out this next week on health provision for children and the degree to which it does not take place and is not financed, that underlines some of the points that you have made. I would emphasize that one of the reasons that, compared to many of the proposals that have been discussed today and those introduced to date, do not meet the same, if you will, comprehensiveness as private employer provided plans.

The advantage of an employer plan and one of its greatest disadvantages, if you will, is they do not approach it in a piecemeal fashion. The long-term care programs being marketed today and provided by the employers—the small number now providing them—provide for the inclusion of children. They provide, under the definition of dependents, for the inclusion of one's parents, as well as for the worker and the worker's spouse.

That is the advantage of them. The disadvantage is that makes underwriting all the more difficult. It creates the data problem and the uncertainty problem I mentioned, as well as it creates much fluctuation in pricing, which is one of the reasons that market is developing—we might say—very, very carefully and slowly.

Senator **Chafee**. Mr. Salisbury, my time is up; but I do want to say this: No one is going to challenge my credentials in looking after the elderly, and I am for that. But also, I am deeply concerned about the other members of our society and particularly our children.

And I want to work toward legislation that will provide long-term care for all Americans. What disturbs me is that sometimes I feel the train is leaving the station without a very important segment of society aboard; and I hope, Mr. Chairman, that everybody will turn their attention to that subject as well.

Anybody who was here for those hearings couldn't help but be moved by the challenges that young people—children—and when I say the children I am talking under 18—are facing in our society.

Before they are born even, lack of proper prenatal care in the United States is shocking. And proper post natal care is dismal in many instances.

So, Mr. Chairman, I hope we can keep our focus on all Americans, as well as this group that we are deeply concerned about here today. Thank you, Mr. Chairman.

Mr. **Ball**. Mr. Chairman, could I make one comment?

Senator **Packwood**. Yes.

Mr. **Ball**. The comment is about what Mr. Salisbury said about employer sponsored plans as a solution in this area of long-term care. The plans so far—and there is a very limited number of them—are the kinds of plans that are a big advantage over individually sold policies; but they are employee paid for. That is, the employer performs an administrative and a selling function, and that is worth doing; but you still end up with an employee paid-for plan.

The suggestion that Mr. Salisbury made that perhaps could be changed by adding this as one of the things in a cafeteria plan means, of course, that individuals choose among the kinds of benefits that they elect. And although that might extend coverage some, it seems to me no conceivable possibility that, in choosing among different kinds of employee benefits, that you would get anything like the 85 percent protection for long-term care of the population generally if the changes are made that he suggests.

I would guess rather like seven percent, something like that. I just thought that the disagreement we have ought to be in the record.

Senator PACKWOOD. What if you mandated it?

Mr. BALL. Oh, mandating? Sure, that is something else.

Mr. SALISBURY. I would go to the next step, which is simply to point out, based on the seven percent estimate, that thus far employers even with employee pay-all are achieving rates higher than seven percent voluntary participation; and that is in the absence of any tax incentive for those employees making that choice.

So, while I described 95 as probably a high water point, I would simply suggest that I think a seven percent is a bit too pessimistic.

Mr. BALL. Okay, ten.(Laughter)

Mr. SALISBURY. That is lower than has already been achieved without any tax incentives. I would also like for the record to be clear that your implication and choice of words that I was saying employer plans could be the whole solution to this problem is not what I said.

I said that they could be a component of an overall solution, and that they probably could help in a case where there are limited resources to be allocated, even as your proposal articulates.

Mr. BALL. I agree with that. I just wanted to make a clear distinction between employer sponsored plans paid for by employees and the employer paid-for plans because you get a very different kind of structure, particularly about your ability to cross-subsidize——

Senator PACKWOOD. Let me ask Mr. Salisbury a question. I would assume in some of these plans that they are not totally employee paid, that the employer may be picking up part of the cost.

Mr. SALISBURY. In the current long-term care programs, that is not the case; the employers are not because of the tax issues that I have just mentioned. I think that would, in fact, change. I think, per Bob's point, most cafeteria plans do not—for example, in the health insurance area—provide the option of going without any health insurance.

They may provide the ability to just choose catastrophic, for example; and there is absolutely no reason vis-a-vis long-term care that there could not be a minimum catastrophic long-term care benefit as a mandatory piece by the employer of that particular package.

So, I think that we could debate all day over the aspects of benefit design, but Bob and I can do that separately.

Senator PACKWOOD. Let me ask you this, Mr. Salisbury, and then I have to run pretty quick or I will miss the vote. Every time we talk about mandating anything—whether it is Senator Kennedy's mandated health benefits—the employers are up in arms about mandating benefits, although we mandate workers' compensation at the State level, unemployment compensation, and Social Security.

If we are determined—and I think we are—that there is going to be long-term coverage, why not take care of at least the bulk of it by mandating it on employers? And we can decide whether we want them to pay for it all, or half and half; and Mr. Ball is suggesting a point three percent on both employers and employees—why not mandate it?

And we would have to mandate the level of benefits then. We would say to the employer: Fine, you go buy it from Employers Mutual or Travelers or wherever you want to buy it. But at least, it would keep the Federal Government out of the management of that great portion of it.

Mr. SALISBURY. Senator, I know that one of the reasons that Mr. Ball frequently wins more victories on Capitol Hill than some employers is because he shows much greater flexibility and much greater recognition, at times, of what is or is not inevitable.

I mean that as a clear compliment because I think in this case, if employers were to open up their eyes to the fact that there is an inevitability of Government action to deal with this very, very serious problem and they took that as a reasonable given and then were given the choice between either doing it with a mandate or with a Government program, they would probably be more than happy to say: Solve a good deal of the problem or part of the problem with a mandate.

Senator PACKWOOD. Mr. Salisbury, I have to run right now, but please tell them—and you know them better than anybody—that it is coming. (Laughter)

Mr. SALISBURY. May I quote you? (Laughter)

Senator PACKWOOD. You may quote me and everybody else on this committee. I mean, as sure as we are here, if you pick up anything when you go home, it is coming. I remember what Howard Baker once said—I mean, assuming that you don't like this and count it as a disaster—he once said: You know, of a dozen disasters coming down the track toward you, don't worry about it. He said: Eleven of them are going off the rails before they get there, and the twelfth one is going to ride over you; and there is nothing you can do about it, anyway.

This one, if you don't like it, is going to run over you; and I would rather have you be on the train than under it. Would you mind waiting because I think the chairman may have some more questions.

Mr. SALISBURY. I would just note, Senator, that I hope you will insert in the record instead of "you," "employers" since I would attribute it to them in their not recognizing reality versus myself.

Senator PACKWOOD. I have found you very, very realistic in all the years I have known you. Would you just wait until the chairman comes back in case he has any questions?

Mr. SALISBURY. Thank you, Senator.

[Whereupon, at 11:39 a.m., a brief recess was held.]

AFTER RECESS (11:40 a.m.)

Senator **Mitchell**. We will resume the hearing. Mr. Salisbury, I just have a couple of questions for you. You commented on the tax provisions in my bill which are intended to encourage the further development of private insurance in this field. One of the problems we have is in connection with attempting to estimate what will happen.

You talked about the possible market that exists, and you referred to employers of 250 persons or more. But we, in another context, have received a lot of testimony and evidence regarding the increasing number of persons who are without health insurance and the increasing proportion of them who are employed persons or their dependents.

The impression is inescapable that employers, and particularly small and medium sized employers and particularly some in some aspects of the service industry, are increasingly not offering health insurance, that you are not seeing a big increase. In fact, the increase is occurring in the number of persons who are working but don't have health insurance.

I have really a two or three part question. Is that impression accurate? If it is, is it not then counterintuitive to think that, if people are not offering health insurance or at least increasing that, they are likely to add to the benefit level in health insurance? Won't that work the other way?

What is your impression of what is occurring in the country today?

Mr. **Salisbury**. One is that you are continuing to get marginal increases in the number of people with health insurance as well, even though the number without is in fact increasing. As a result of health care cost management concerns and containment concerns, we are seeing employers move much more to copayments, deductibles, and other things aimed at cost sharing, which are including premium cost sharing that are causing some employees to choose not to purchase family coverage because they don't want to pay the differential.

And we are also seeing in some growing number of cases, which is what I will describe as one of the potential shortcomings of cafeteria plans, some individuals where given the option to choose no health insurance and instead to choose more money into life insurance or some other benefit, are totally opting out of health insurance protection, or are choosing not to buy protection for their families.

However, choice does have its disadvantages. Senator Packwood made a point just as he was leaving, which was, if we are talking about providing protections through either a public or private means and if our means of providing that protection is one way or the other going to be mandatory, which your bill clearly has that component to it, then his question was: If we made that mandatory on the employer, how much could we achieve before we moved to a direct public program?

If we hypothesize that every employer provided plan must be provided to all workers and the worker must pay some level of copayment—which is a Kennedy bill proposal—if we were to say every individual must provide for family coverage and include their children, if we were to go a third step and say every private employer plan must include as a piece of that plan a catastrophic long-term care piece, and changes such as that, then we would achieve the levels of coverage that are in fact in place today, based on that series of mandates.

If the choice is mandating public program versus those approaches to a private program, you are creating similar results in many cases.

A piece of the process that always concerns me a bit is the degree to which we, in some cases, write off a public approach totally by saying that private can do it but leave it totally to voluntary; or to which we write off the private sector as being able to do it because of the presumption that we will not change the rules for the private sector and, because the voluntary system has holes, those holes will continue to exist.

Versus what I put into the mouth of Senator Chafee as to his question on a more comprehensive approach, just recognize that if we are going to be doing these things in some way that we should take full advantage of the structures already in place.

And if that means in some cases mandating, then so be it, in order to achieve the objective laid out. Now, we can all argue over what objective is the most appropriate.

I think in terms of a final comment on your three-part question, the level of dissipation of coverage in private health insurance is relatively "minor." As the population grows,however, the number of people who will not have health insurance, which depending on whose numbers you believe—our own approximate 37.5 million Americans today, and our numbers on children approximately 10.6 million without health insurance—those numbers will invariably continue to grow if we stay with the set of systems and programs in place today.

And to the degree health care cost inflation continues, most insurance companies this year are looking at potential increases of as much as 21 to 28 percent on top of last year's increases, then it is inevitable that we will have further problems in coverage.

On the other hand, I would have to note a balance vis-a-vis paying for proposals like those discussed here today, vis-a-vis paying for catastrophic Medicare coverage, vis-a-vis paying for basic Medicare coverage—those kinds of inflation rates are going to affect those programs and those long-term cost estimates well, which simply says it is a problem with regard to all of the programs.

I think the challenge is to be comprehensive with it, to not just look to public or just look to private, and to figure out—as your bill takes an extremely effective first step of doing—of trying to create that comprehensive approach, even though as you have candidly stated many times in your written statements and your oral statements that there is a tremendous amount of room for all of us to work very, very creatively in the months ahead towards the inevitable outcome—if it is, as Senator Packwood was suggesting before he left.

Senator MITCHELL. Thank you very much. Thank you all for your testimony.

Mr. Ball. Could I just make one comment on that, Mr. Chairman, on what Dallas said?

Senator Mitchell. If you wish, yes, but we do have another panel, and we need to try to finish here.

Mr. Ball. Right, very fast. I just wanted to tell you, so you have the numbers there, that between 1978 and 1984, the number of persons without health insurance has increased, as you were suggesting, from 28 million to more than 37 million. That is the trend.

Senator Mitchell. All right. I don't think there is any dispute on that.

Mr. Salisbury. Those are our numbers.

Senator Mitchell. Right.

Mr. Salisbury. The institute was the first to present comprehensive tabulations of Census Bureau data on health care non coverage. I will share the full report with Bob, happily.

Senator Mitchell. All right. Thank you both very much, and thank you, Ms. Crooks.

The next panel includes Ruth Von Behren, Adult Day Health Care Specialist, On Lok Senior Health Services of San Francisco; Val Halamandaris, President, National Association for Home Care; Paul Willging, Executive Vice President, American Health Care Association; and Joan Quinn, President, Connecticut Community Care of Bristol, CT.

Good morning, ladies and gentlemen, and welcome. We are grateful to you for taking the time to come and provide us with your advice and counsel this morning. We will begin with Dr. Von Behren. Welcome.

STATEMENT OF RUTH VON BEHREN, PH.D., CHAIR, NATIONAL INSTITUTE ON ADULT DAY CARE, ON LOK SENIOR HEALTH SERVICES, SAN FRANCISCO, CA

Dr. Von Behren. Good morning. Thank you very much, Senator Mitchell, for giving me the opportunity to comment on your bill. I applaud you for the courage that you have in bringing together the most comprehensive legislation that up to now we have on long-term care.

And I agree with your statements earlier today when you were talking about what we need is a comprehensive system and that, indeed, funding does drive the system; and we do need options.

I am speaking on behalf of adult day care, and I represent the National Institute on Adult Day Care, which is part of the National Council on Aging.

Our concern with your bill is with the role in which you have placed adult day care. You have put it under the home and community based respite services. We feel that adult day care is a service that goes beyond just the respite aspect of it.

Earlier, it was mentioned that home and institutional services are important, but there is a third group within this comprehensive system; and this is the community-based care. And adult day care is, I think, a vital player within this community-based system of care.

We would like to see it included in your legislation as a full partner and a full program under Medicare reimbursement.

So, what we are suggesting is that we would like to have you delete adult day care as it now is spoken of as a respite service; but we would like to see you bring it in under Title I of the bill, bring adult day care in as a specific benefit as a equal service with chronic home care services and institutional services.

We suggest that S. 1839, which has been introduced this session by Senators Melcher, Bradley, and Heinz, can provide to this committee the elements necessary to define adult day care as a Medicare benefit under S. 2305.

I should say, incidentally, that S. 1839 is now cosponsored by 15 Senators, including your colleagues on this Finance Committee, Senators Durenberger, Moynihan, Matsunaga, and Chafee.

S. 1839 does establish adult day care as a benefit. It has the same kinds of detail which you have in regard to the chronic home care. It establishes eligibility criteria; it establishes certification standards; and it establishes the service package. In other words, all the full components of the service are included in this bill.

We think this would strengthen your bill by bringing in a community-based service as a full partner in the comprehensive system which is needed for long-term care.

Medicare reimbursement is needed for this program. It is now being funded by a variety of Government sources; we can find adult day care programs in all 50 States. Forty-one of our States do have standards affecting this program.

The problem is, as was stated earlier, the persons who are not quite poor enough for Medicaid but not rich enough to buy what they need.

Last week, I toured rural Kansas; and I met with a number of groups of senior citizens in regard to the problems they are having in receiving health care and long-term care. What I heard repeatedly is: We cannot afford it; even if the services are there, we cannot afford it.

We do need Medicare reimbursement. I also would point out that Medicare reimbursement for adult day care has a potential of providing a monitoring system for the health needs of the frail, impaired individuals that would also control and possibly diminish hospitalization.

I will give you an example from my own agency, which is On Lok Senior Health Services, of which adult day health care is a very vital part. We have found that we are able to cut hospitalization utilization for impaired elderly, who are eligible for nursing home care. Our hospital utilization is 25 percent less than the hospital utilization for the regular Medicare population, which is a healthy population in general.

We do have some other concerns with this legislation, which we have stated in our written statement. I think our main concern is that, as we now have this debate on what are we going to do about long-term care, we would like to see you recognize adult day care as an option—a viable option—and included in your legislation.

[The prepared statement of Dr. Von Behren appears in the appendix.]

Senator MITCHELL. Thank you very much, Dr. Von Behren. Mr. Halamandaris, welcome. As always, we who have benefited from your testimony in the past, look forward to hearing from you.

STATEMENT OF VAL J. HALAMANDARIS, PRESIDENT, NATIONAL ASSOCIATION FOR HOME CARE, WASHINGTON, DC

Mr. HALAMANDARIS. Thank you, Senator. I appreciate very much being invited to testify today. I would like to commend you for introducing your bill, S. 2305. I think it is a wonderful start.

I would also like to commend you for the fantastic work that you have done to make this issue the number one domestic issue in America. Before it got your attention and the attention of the Senate Finance Committee, long-term care ranked very low in terms of American priorities.

Thanks to your efforts, it is now the number one issue; and I would like to commend you for that.

With your permission, Mr. Chairman, I would like to enter my statement in the record and summarize it briefly.

Senator MITCHELL. That will be done.

Mr. HALAMANDARIS. Mr. Chairman, long-term care has been an obsession for me; for over 20 years, I sat on that side of the dais as counsel to the Senate and then later to the House Committee on Aging. I am very, very pleased to see that your bill incorporates most of the major recommendations of the Senate Aging Committee which took 8 years and over 30 hearings to develop a suggestion for a program of long-term care.

What the Senate Committee on Aging recommended in December of 1974 is very similar to your bill. There were such giants as senator Frank Moss and Ed Muskie and Phil Hart who put their life's blood into developing this report; and I think it is important that we recognize their contribution and the fact that your bill continues their good work.

I don't wish to give the impression that I have all the answers, but there are a few comments that I would like to make.

First of all, I think this works as an entitlement program and not a means tested program, and your bill meets that test. Second, it is important that we have a Federal program, federally administered, and not a bifurcated Federal/State program. Once again, your bill meets this test.

In terms of financing, I am very comfortable with the method that you have chosen. I think I would have preferred Senator Pepper's suggestion of removing the $45,000 cap and make it a Social Security tax, more progressive.

All but five percent of the American public now pays the Social Security tax on all of their income. There is no reason in my judgment why the remaining five percent should not do the same; and I am only talking about paying the 1.45 percent on total income.

In the past, I have also advocated the use of Federal excise taxes on alcohol and tobacco because the connection between use of alcohol and tobacco and health problems is well known.

The fourth point I would like to make is that a separate trust fund is vital, is crucial; and your bill incorporates that suggestion.

The next point that I think is crucial is that your bill makes home care the priority. You heard Robert Ball talk about the importance of making home care the first line of defense, and I think that is crucial. That is where we have to start.

We have to reverse the institutional bias that we have in the United States. The Senate Committee on Aging said that 12 years ago; and what they said is just as apropos today as it was then.

I also think that you have done a wonderful thing to include respite care and day care. Those options are equally crucial and, in my view, should be provided simultaneously.

Then, I think it is important that you have included nursing home care; and I would include it in precisely the order that you have, as a last resort. The American public, the elderly in particular, still have very negative feelings about going into nursing homes.

As the Senate report said, going into a nursing home is viewed by the elderly as not only synonymous with death but with protracted suffering before death. So, let's be careful that we don't sell tickets to a train no one wants to ride.

It is important that we provide nursing home care and the best of nursing home care, but only as a last resort, as you have provided in your bill.

The next point I would make, Mr. Chairman, is that it is very important that we educate families to care for their own and not to dump the elderly on the State. I think we could use some provisions in your bill which would encourage families and educate them on how to take care of their own.

Another point that I think needs to be made is that the real issue in long-term care is not age but functional disability.

And I would like to make the case that you include, as Senator Chafee pointed out, the chronically ill children in your bill. There are not that many of them, and they need to be included. If we don't, it will be a mistake; and what we are going to have is an intergenerational conflict. I would sincerely argue that you should consider that.

Finally, I think it is important that we have a bill that is easy to administer, a bill that can be managed; and Medicare, with all of its problems, still manages to run at about four percent administrative costs in Part B, I guess, for around seven percent of the total. And I think we need to keep that system.

I think one of the things that needs to be examined in your bill is how we define case management. That is a crucial issue, as is the issue of how we would draft fee schedules. I was concerned about language in your bill which says "or such other prospective system as the Secretary may determine."

Senator Moss and Senator Muskie had a conversation to which I was privy years ago in which the former said to the latter that the battles that are won on the floor of the House and the Senate are often lost in the Federal Register. And I would suggest that you spell it out and make sure that that doesn't happen. (Laughter)

Mr. **Halamandaris**. And finally, I would say the comments that I have made to you have been reinforced by the Harris poll, which Senator Pepper alluded to, in which 80 percent of the American public decided that they wanted a long-term care program designed along these lines.

Again, I would like to commend you for what you have done, Senator, and the committee as well.

Senator **Mitchell.** Thank you, Mr. Halamandaris. We invite you to help us write it into the law and ask that you submit to us in writing your specific suggestions in that regard.

Mr. **Halamandaris.** Thank you.

[The prepared statement of Mr. Halamandaris and related information appear in the appendix.]

Senator **Mitchell.** Dr. Willging, we have also benefited greatly from your advice and counsel in the past, and we again look forward to hearing from you. Welcome this morning.

STATEMENT OF PAUL R. WILLGING, PH.D., EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION, WASHINGTON, DC

Dr. **Willging.** Thank you, Mr. Chairman. With your permission, I will submit my written statement for the record and summarize briefly.

I begin with a considerable amount of trepidation when I find Mr. Halamandaris and I in general agreement about the value of your legislation. (Laughter)

I fear perhaps I missed something in my first reading.

Senator **Mitchell.** You will notice we were prepared. We separated you by Dr. Von Behren and Ms. Quinn. (Laughter)

Dr. **Willging.** I do share in Val's commendations, Mr. Chairman. I think you are the first in the Congress to submit for deliberation not just a comprehensive long-term care financing bill, but one which in fact deals with fiscal realities as we must deal with them today.

I think you have done that by going beyond lip service to the concept of the public/private merge. We hear that so often, more often than not, the weight is clearly on one side or the other; I think you have very well melded those two concepts together.

And you have also—and here is where I wonder whether or not Val and I are looking at the same bill—because he suggests you have emphasized home care as a priority; I suggest again that you have indeed done what has to be done.

Senator **Mitchell.** Pretty good job on my part, wouldn't you say? (Laughter)

Dr. **Willging.** I think that what is clear in your bill is that you have recognized that the 82 percent of catastrophic health care expenses incurred by the elderly are nursing home care. And that is clear; the data make that absolutely unequivocal.

I think your bill by recognizing the fact that, yes, most Americans do wish—where possible, where feasible, where practical—to receive their long-term health care services in the home ultimately with chronic debilities, the nursing home becomes the option of choice.

Six points very briefly, Mr. Chairman, if I could; and I think in most of these points, your bill does indeed meet what I think are legitimate public policy interests.

As I mentioned, the first is, in fact, the merging of the public and the private sectors. There are those who would suggest and have suggested that a 2-year exclusionary period is too much; but I think that is indeed fiscally prudent but, at the same time, you are not proposing that Medicaid be abolished.

Indeed, you are suggesting a level of effort be maintained for Medicaid. That, I think, will deal effectively with those who are not capable of providing through insurance or other mechanisms for that first 2-year period.

I would disagree quite frankly with Mr. Ball in his testimony that the period for private responsibility should come at the tail end, rather than at the beginning. Obviously, if it comes at the beginning, it makes a much more definable package in terms of the insurance product that this legislation is trying to promote.

I agree with Mr. Halamandaris; we need a dedicated funding source. Long-term care has too long been held hostage to the vagaries of annual appropriations considerations at both the State and the national level. If we wish to preserve quality of care, we have to recognize that the funding source itself has got to be stable.

I think I also share Mr. Halamandaris' concerns that this is probably the only time in history in this town—I will agree with Mr. Halamandaris three or four times in the same testimony——

(Laughter)

On the need to make sure that, again just like the funding source, the rate development mechanisms do not sacrifice quality of care to budgetary considerations. We need to worry first and foremost about the needs of the patient, the acuity levels of patients, and the legitimate costs by providers in providing the services entailed in those acuity levels, and the geographic variations that have to be looked to, particularly in terms of wages and salaries.

I think it important as well that we recognize that rates established for long-term care—nursing home care in particular—are not analogous to those established in the acute care setting. At the risk of perhaps being excessively simplistic, an appendectomy is an appendectomy is an appendectomy.

The day of long-term care, particularly in the institutional setting, can vary broadly in terms of the amenities and services provided above and beyond the base rate. And I do think it important that consumers have the choice to be able to buy those services above and beyond what is entailed in the rate established by the Federal Government.

I think also, with respect to the consumer, that it is important—if as I perceive it, Mr. Chairman—one of the purposes of this legislation is to stimulate the private sector, particularly through long-term care insurance, that we continue the process already begun to provide adequate protections for consumers as they purchase that product.

We support the proposals being circulated by Senator Durenberger in that regard, as we do the work of the National Association of Insurance Commissioners.

And finally, Mr. Chairman, I think it important to continue to look to Medicaid and not as a program in conflict with what you are trying to develop, but a program that could be supportive of what you are trying to develop.

I don't think in this Nation we wish two types of long-term care—that available to the indigent, that available to those who are capable of providing either through your program, in concert with long-term care insurance, a higher level of care.

I would strongly urge that we go beyond demonstrations and provide Federal matching to the States under the Medicaid Program if they choose to in fact purchase insurance on behalf of the indigent within those States.

All in all, Mr. Chairman, we think it is more than just a good start. We think it is an excellent bill. Thank you very much.

Senator MITCHELL. Thank you, Dr. Willging. I know that your organization is, of course, very much interested in the prospective payment plan—the method of reimbursement—under this bill; and I invite you to submit to us your specific, detailed comments on how you believe such a plan should be structured as part of this effort.

Dr. WILLGING. We will do so, Mr. Chairman. Thank you.

[The prepared statement of Dr. Willging and related information appears in the appendix.]

Senator MITCHELL. We welcome your expertise and interest in that area. Ms. Quinn.

STATEMENT OF JOAN L. QUINN, PRESIDENT, CONNECTICUT COMMUNITY CARE, INC., BRISTOL, CT

Ms. QUINN. Thank you very much. I am glad that you put me between all of these providers. They are very essential to care for older people and will continue to be so. Each component part is important.

I, too, congratulate you, Senator, on your thoughtfulness in the development of this bill. I would like to speak to the case management component in particular, having worked and developed initially under a 2176 waiver program in 1974 called Triage in Connecticut, a program of case management.

It was when Val was on the other side of the aisle, and Senator Packwood was very helpful to us. He probably doesn't remember, but he was back in 1974.

That became a State-wide program in Connecticut called Connecticut Community Care. It currently serves over 5,000 older adults each month in a community setting who have episodes when they need nursing home care, but our focus is really on de institutionalized care.

I think that case management is a vital component of any long-term care program. It is a successful method to address the current fragmented service and reimbursement system. It provides for the clients and their families a very thorough assessment, care planning using existing providers—both in the community and in the State—a myriad of service reimbursers, and a system that is very complicated to try to maneuver.

Therefore, it advocates as a service for the client. There is cost benefit because you really match the client to the exact services they need in the right amounts and at the right time; and there is very much an educational component of the program because you do educate families and the older adults themselves and, in some instances, younger adults as well, as to the service system and the reimbursement system for the service and how much they have to contribute.

In today's system, there is much out of pocket expense incurred by the family in long-term care.

The independence of the case management function, as you mention in your legislation, I feel is very important. I don't believe that it should be tied to a provider, nor do I believe it should be tied to the reimbursement system; and the case management agency does have better control if it can control the resources for some of the services ordered.

In terms of creating an infrastructure of case management services around the country, I think that is beginning. There are approximately 10 national case management agencies that are beginning to work together to develop a uniform method of providing quality case management services.

The National Council on Aging very soon will come out with standards for case management which will help in that effort. So, I think the infrastructure is being developed in terms of the case management.

I do believe that the case manager function does save money for the payer, as well as meet the needs of the individuals themselves. We have a 2176 Medicaid waiver program in Connecticut that we are administering, and there is cost saving in that program by providing community services in lieu of the nursing home services when it is appropriate.

I feel there is a great need for creating viable service delivery alternatives for relieving families of the stress that they are experiencing right now, that services should be provided in a diversity of locations, and that there should be some financial protection for older people against the catastrophic costs of long-term care, not acute short-term care, but long-term care; and that really partnerships forged between the client, the private and the public sectors are really a response to this problem. Thank you.

[The prepared statement of Ms. Quinn appears in the appendix.]

Senator MITCHELL. Thank you very much, Ms. Quinn, and all of you for your very thoughtful and informative testimony.

Senator MITCHELL. Senator Packwood, do you have any questions of this panel?

Senator PACKWOOD. No, I have no questions. I will just restate what I said when you were not here before, principally to Mr. Salisbury.

A long-term care bill is coming—no question about it. For those who want to put up their hands and say "No," they are going to get rolled over. Maybe we will pass a bad bill if we don't have their help; but we are going to pass a bill.

And I would love to have the private sector involved in this to the fullest extent they can be involved, but, for whatever reasons choose to be only minimally involved, it will happen.

Senator MITCHELL. I think if I could comment on that, Senator, I agree with you. I have seen an interesting, somewhat disturbing, transformation occur in abuse of the private insurance industry over the past year. I have been meeting with them regularly. I have had dozens and dozens of meetings.

At the outset, when I inquired as to what the most difficult obstacle was to the development of private insurance in the field, I was told it was the inability to specify or identify the risks. That led me to the concept of a substantial exclusionary period, to precisely define the risk.

When I initially proposed it—in fact we had hearings last year on the subject—a substantial portion of the industry was supportive of the concept, not all. Gradually, over time, the industry appears to be operating on the belief that they can defeat any effort, that there isn't going to be a bill; and their best tactical approach would be to oppose any effort.

I have tried to make the point which you just made. I think something will occur, and the choices very likely are to be either the kind of exclusionary period I have proposed or something along the lines that Mr. Ball has proposed; and I know that Senator Kennedy has publicly stated his proposal—that is, first day, first dollar coverage.

So, I think obviously everyone will act out of what they perceive to be their self-interest, but I think there is a profound misjudgment being made that could result in something that is much less desirable from the industry's standpoint.

I think something is going to happen. We have tried to make provision for that development here, particularly in the tax provisions, which I think will be helpful. But I sure welcome your interest and participation, and we are very grateful to you, ladies and gentlemen, for your testimony.

As I indicated in my requests to Mr. Halamandaris and Dr. Willging, we look forward to your further input on the areas in which you have a special expertise and interest.

Ms. Quinn, I have had the pleasure of meeting with you before and receiving advice from you; and I think case management is going to be a critically important part of this or any other program, both to assure quality and to control utilization.

Dr. Von Behren, I might say I had the pleasure of visiting an adult day care center in Maine, as I was in the process of developing this legislation, to see for myself how it functioned and what services were offered. It was a very heart-warming experience and I am pleased that it is included in the bill; and we look forward to reviewing your suggestions for improving it even further.

That concludes the hearing. I thank everyone very much, and we look forward to working with you all on this in the future.

Oh, I apologize. Excuse me one second. (Laughter)

Senator **Rockefeller**. Mr. Chairman, I had one question.

Senator **Mitchell**. Senator Rockefeller sneaked in without my observing him, and I am very embarrassed and apologetic. Senator Rockefeller, please, do you have any questions?

Senator **Rockefeller**. I mean, I recognize that I am junior around here, but—(Laughter)

Senator **Mitchell**. Well, there goes one vote. (Laughter)

Senator **Rockefeller**. Just one question for Mr. Halamandaris. The extended family is such a powerful concept generally, and it certainly is in West Virginia. One worries that if Medicare started to pay for home care services there could be an instinct on the part of some families, which have been doing so much and making so many sacrifices, to retreat from this process of so-called "informal care" in the home.

Now, I recognize that it is not one extreme or another; but my question is about this connection between Medicare payment and informal family care do they conflict?

Mr. **Halamandaris**. Senator, I appreciate your concern. There have been a number of studies, most recently one that was released by the Brookings Institution, in which this was evaluated pretty thoroughly; and the studies are unanimous in their conclusion that that kind of substitution does not happen.

Indeed, the opposite happens, that the families continue to care for their elderly, even to the point of breaking. In other words, the family will fall apart—the stresses are so great—that they carry the burden beyond the point where they are able to cope with it.

I suggested in my comments that we need to do more to educate families on how to bear that burden and educate them on how to care for their own. But I am not concerned that, if the Government were to suddenly make some benefit available, that families would begin to dump their senior citizens into nursing homes or substitute the paid care for nonpaid care.

The evidence just isn't there to support that; it is on the other side of the ledger.

Senator **Rockefeller**. Thank you very much. Thank you, Mr. Chairman.

Senator **Mitchell**. Thank you, Senator Rockefeller, and I apologize again. The hearing really is now over.

[Whereupon, at 12:17 p.m., the hearing was adjourned.]

LONG-TERM CARE ASSISTANCE ACT OF 1988

FRIDAY, JUNE 17, 1988

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to recess, at 9:30 a.m., Hon. George J. Mitchell (Chairman) presiding.

Present: Senators Mitchell, Baucus, Packwood, Chafee, and Heinz.

[The prepared statements of Senators Rockefeller, Chafee and Heinz appear in the appendix.]

OPENING STATEMENT OF HON. GEORGE J. MITCHELL, A U.S. SENATOR FROM MAINE, CHAIRMAN OF THE SUBCOMMITTEE

Senator MITCHELL. Good morning, ladies and gentlemen. Today, we will hold the second in a series of hearing on the Long-term Assistant Act of 1988. Specifically, we will discuss today the role of private insurance in the development of a comprehensive long-term care policy. We will also hear from those who administer long-term care programs in the States in an attempt to learn from their expedience.

When I introduced this legislation I did so to begin a national dialogue on the delivery and the financing of long-term care. This bill is not presented as the ultimate solution to the problem or even the best solution. It is rather an effort to begin a process that hopefully will culminate and reforming the way long-term care services are delivered and paid for.

Nearly all States spend at least half of their Medicaid dollars on nursing home care for the elderly. The financing of long-term care is dominated by out of pocket cost of the elderly and the Medicaid program, a program intended to provide basic health care to the poor of all ages. Medicare pays for only about 2 percent of nursing home costs nationally.

Private insurance coverage for long-term care is in its infancy. Very few policies exist, and those that do are often inadequate to meet the cost of care.

Under my bill, nursing home benefits would be available to those Medicare beneficiaries who qualify, Medicare would begin to reimburse for these costs after a 2-year exclusionary period. After the exclusionary period, reimbursement would be available for an unlimited period but a 30 percent co-payment would be required.

The exclusionary period for the nursing home benefit is the subject of much debate. Some do not support this concept; others believe a private/public partnership for long-term care is the only feasible way to proceed.

The proposal for nursing home care is the result of substantial consideration and is a compromise. The trade-off between benefits and cost is real. The length of the exclusionary period is pivotal. A short exclusionary period will provide a much more comprehensive benefit with coverage available more generally, but with an extremely high public price tag. A longer exclusionary period decreases the public cost but provides less relief for those forced into poverty by spending down into Medicaid.

My approach has been to decrease the exclusionary period as much as possible, given realistic funding limitation. Decreasing the exclusionary period dramatically increases the cost. Moving from a 2-year period to a 1-year period in 1993 will increase the cost by $10 billion a year.

A central factor in whether or not my approach succeeds is the response of the private insurance industry. If private long-term care insurance becomes widely available at reasonable cost this approach will succeed. I have had many, many discussions with representatives of the insurance industry in an attempt to determine what level of response can be expected in the development of long-term care insurance. The subject has been of interest to many organizations and many members of Congress.

The policy issue we face is how to target our limited public resources to the elderly most in need while at the same time retaining the social insurance contract that exists throughout our Social Security system. The issue is not trivial nor easily solved.

This proposal has been criticized from two diametrically opposite points of view: Those who prefer a program providing full and comprehensive coverage, that is, for reimbursement of nursing home expenses from the first day of eligibility, they say my bill doesn't go far enough; those who are opposed to any Government program and are opposed to any new revenues to pay for any such program say it goes too far. So it is important that it be clearly understood what this proposal is and what it is not. It is not a comprehensive public program to provide reimbursement for all services rendered. It is, rather, in its public aspect intended to protect American families against the catastrophic cost of very long-term care. It is a form of public insurance policy against the extraordinary expense of very long-term care that will be incurred by a minority of elderly Americans who cannot be individually identified in advance.

Obviously the gap in the public program is created by the exclusionary period. The bill seeks to fill that gap by encouraging the development of private insurance to cover expenses during that period.

I seriously considered a wholly comprehensive Government program, but elected the alternative contained in the bill for two reasons. First, our health care system is already part public and part private. Although there are shortcomings in that structure, on balance it has provided most Americans with ready access to high quality medical care. This bill extends that structure to the problem of long-term care.

Second, the cost of a fully public program is very high, making its political feasibility doubtful. It will be extremely difficult to gain the necessary support for even the limited program suggested in this bill. The broader the coverage, the higher the cost, the more difficult enactment becomes.

There is a tension growing between the need to allocate our scarce resources to meet the most urgent needs and the desire to support the social insurance concept in which benefits are not related to income. This bill tried to do both. It is based on the social insurance concept that once a beneficiary becomes eligible for benefits, and the exclusionary period expires, the benefits are identical for all beneficiaries regardless of income.

I look forward to the testimony to be presented by our witnesses today. It will take a concerted effort by the Federal and State Governments, advocates for the elderly, and the private insurance industry to determine the best way to develop a national policy for the delivery and financing of long-term care.

I am pleased to be joined today by the distinguished former chairman of the full committee, Senator Packwood. Senator, do you have an opening statement?

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON

Senator PACKWOOD. I do, Mr. Chairman. Thank you. And I know the criticism that you are taking from those on one side who feel that you have too big an exclusion, and people are going to have to pay too much up front, and some of the criticism that Senator Moynihan took on his Welfare Reform bill, that it did not go far enough. I come at this from a slightly different viewpoint in terms of how it might be produced. Part of it comes from my experience when I was a labor lawyer, bargaining contracts, representing employers. I would look at it as follows. Are the people in the country entitled to long-term care? Do they deserve it? Do they need it? Yes. Can they afford it personally? In most cases, no. A few can. Even if they were to be frugal and put money aside, it is unlikely, because the amount that they would have to put aside for any substantial stay in a nursing home is more than most people can afford. If the Federal Government were to provide it, do we do it any more cheaply than if it is provided by private industry? And there I hope the argument that used to exist 20 or 30 or 40 or 50 years ago, that if we eliminate the middle man, the Government can do it cheaper, is gone.

Anyone who looks at any GAO reports over the last 50 years or anyone who has had any hands-on experience in Medicare or Medicaid or the Government management of anything where we actually are involved in the program, is hard-pressed to think that we can do it cheaper than private enterprise. Are we more humane? Are we better managers? I don't think so.

I have always wondered how we won wars with a Government army until I realized we are fighting other Government armies. (Laughter)

And as long as we have superior productive power we can grind them down.

We have had some successes in social benefits provided by employers in the past. Workers' comp is a good example. The Federal

Government, even State governments, are not particularly involved in the management—a few States where they have monopoly systems—but the bulk of them are not involved in the management of workers' compensation. They pass a statute, say if you lose a hand you are entitled to $20,000, whatever the statute says. Then we say to the employer, all right, Mr. and Ms. Employer, you go out, and you buy from Aetna, Continental Casualty, or Employe's Mutual, wherever you want to buy it, but you have got to make sure that your employee gets $20,000 if they lose their hand.

We set the standards; we do not attempt to manage the program. And we do somewhat the same in unemployment compensation. A little stronger hand on it, but, by and large, it is employer-financed, and we give the States some leeway in the standards, and we say as long as you have sufficient reserves, and put the money together, and there is unemployment, people collect it. It has worked not badly as a system.

Health coverage for the average employee is a different situation. We did not mandate it, but here is where my experience in labor law comes in.

Years ago we changed the law so that the value of health coverage provided by employers was not counted as taxable income to the employee. It makes no difference to the employer whether the employer pays you $100 worth of wages, which is a deductible business expense, or $100 worth of health benefits by the policy, which is a deductible expense. It is the same $100 for the employer. But to the employee, they pay tax on $100 in wages and they do not pay tax on $100 in health benefits.

So in the 1950s—unions began to bargain for health benefits and the business agent understood it very well. The business agent understood the difference between taxable free fringes and taxable income. The employers, ironically, fought health insurance only to the extent that they thought it made their total cost too much, because they were thinking in their mind, I am willing to pay a certain total compensation. Let's say it is $5 now. They did not care whether it was $4 in wages and $1 in fringes, or $4.50 in wages and 50 cents in fringes. They were thinking of total compensation. All they didn't want to get dragged into was some fringe benefit programs where the costs might escalate so badly, and people had gotten used to it that they would not be able to control their costs in the future.

And here, interestingly also, the unions had great success, and their greatest success probably ended up producing one of their greatest failures.

The employers, sort of half willingly but not fully willingly, went along with this health coverage. Those employers who did not want to be unionized went along with it because they did not want to be unionized, and they did not want the union employers and the union to be able to say, join our union; you will get health benefits.

And so gradually the union succeeded in providing, first, pervasive coverage for union employers and then pretty pervasive coverage for non-union employers. And so in the 1960s when the AFL-CIO had as one of its top items national health insurance, they, at the same time, were bargaining to provide—and they meant Federal health insurance—through the work place. And, finally, they were so successful in providing it through the work place that the demand for national health insurance disappeared.

You take the average Jane and the average Joe in this country working at the shoe store, working at Nords Drugs, working in the lumber mill, you go to the coffee shacks. They will ask you about gun registration. They will probably ask in a moment about Carl Rowan it would be my guess if we go to the coffee shack. They will ask about abortion. They will ask about cigarette taxes. They do not ask about national health insurance, because it has been taken care of for the average. Not for the 35 million that Senator Kennedy would cover—those are not workers; that is workers and dependents; they do not have any coverage. But if you mean 35 or 36 or 37 million people in this country, counting dependents, are uncovered, it means about 200 million people are covered.

So as we look toward long-term care, should we simply say either the Federal Government has to provide it or encourage it, or would there be a way that it could be mandated on employers and the employers pay for it, because, in the long run, they are going to pay as much, whether they provide it themselves, or whether we tax them and provide it.

And one of the frustrations I find, if you were to say to an employer, because they opposed, of course, workers compensation when it came on and unemployment compensation when it came on. They opposed social security when it came on. They opposed even withholding as an undue expense when we began to withhold taxes on employees. They will argue they cannot afford it. And then their associations will argue against any kind of Federal coverage, and then they will get something they do not like, badly managed, overly priced, for which they will pay.

So I would hope we could reach some accommodation where the great bulk of this could be provided through the work place. And it could, and it will not be any more expensive than if we try to provide it any other way. But if we do not succeed in providing it through the work place, it is going to be provided anyway.

The train is coming down the track, and I would rather have the opponents on it than under it. But it is coming down the track in any event, and the choice is really more theirs I think than ours as to how it is handled.

Thank you, Mr. Chairman.

Senator MITCHELL. Thank you, Senator Packwood.

We are pleased to be joined this morning by the distinguished Senator from California, Senator Wilson, who has long had an interest in this area, and has legislation affecting Federal employees. Senator Wilson, welcome, and we look forward to hearing from you.

STATEMENT OF HON. PETE WILSON, A U.S. SENATOR FROM CALIFORNIA

Senator WILSON. Thank you very much, Mr. Chairman. Let me congratulate you and Senator Packwood on excellent statements, very thoughtful statements, which I think have been not only provocative but provided an interesting setting for what I wish to offer this morning.

I thank you for the opportunity of coming to address the distinguished subcommittee.

Mr. Chairman, this April when you introduced your S. 2305, I heard you say at the time of introduction that you hoped to begin a national dialogue on the delivery and financing of long-term care. I want to participate actively in the dialogue and in the process of reforming the way our country approaches ensuring access to long-term care.

These hearings on your long-term care bill have enormous significance to the whole of Congress, particularly after the House vote on the Pepper bill last week. I think defeat of the Pepper bill confirms much that you and Senator Packwood said this morning. I think it is a pretty clear indication that Congress still has grave reservation about committing substantial Federal funds to finance a further expansion of Medicare, or as you described it, a package that is totally Government-financed as opposed to the approach that both you and Senator Packwood have placed a strong emphasis upon this morning, that is, some combination of a public and private treatment of this problem.

Most members I think would agree that Congress can find a viable solution to this problem without imposing what they consider unrealistic new expenditures upon the Federal Government or upon those who pay for Medicare coverage.

Now despite the very hard, and the very thoughtful, very careful work which has gone into your bill—and I really do think that it is a very extraordinary effort—it seems to me that there is also reason to believe that the cost of that bill alone will likely make it difficult for a majority of the 100th Congress to swallow. But that does not mean that we cannot make progress, and that Congress cannot and will not at least take some first step, perhaps some more targeted long-term care, so the bill can pass this year as we continue to wrestle with the complexities of comprehensive bills such as your own.

Everyone in this room knows the urgency of finding ways to make affordable quality long-term care coverage available to the many Americans who need it. And while I think that Senator Packwood's fascinating historical treatment of how those who proposed a comprehensive treatment actually incurred a kind of private participation that perhaps invalidated their long-term goal. It is I think very much true that there does need to be a new approach taken. If their success no longer produces that issue as the most topical in the coffee shop, it is, nonetheless, true that even in comparison with so-called catastrophic illness, the knawing anxiety of the need for long-term care, of sustained nursing home care, is increasingly a concern of older Americans. I guess we are once again proving what Clare Booth Luce said when she said that no good deed goes unpunished. American medicine has been rewarded by a great success in allowing us to live longer and in most instances live better. But as we grow older and geriatric concerns become more and more a part of medical school curricula, it is necessary too that we find a way to respond to that knowing anxiety as to how Americans, as they do grow older, will be able to obtain and afford the kind of nursing home care that is increasingly their expectation.

As you pointed out in your statement, Medicare covers only 2 percent of nursing home expenses, private insurance coverage only 1 percent. That means that Medicaid and uninsured individuals now must struggle to cover the majority of the financial burden that long-term care makes necessary.

And every time I go home to California I hear stories of anxiety and fear from the elderly and from their children concerned with how they will be able to provide decent care, care that they will have to afford, along with their other burdens, for their parents.

Working individuals worry that without affordable long-term care insurance they must save enough money to try to protect themselves against the eventual enormous cost of long-term care.

Retired elderly who still live independent lives, agonize that at any day they may lose everything they have worked for if they suddenly sustain an illness which makes unaffordable the high rates of private insurance or the even more devastating cost of having to try to find and obtain nursing home care for a prolonged period.

Those living now in nursing homes live in anxiety and fear as they continually spend down their savings and risk becoming impoverished in the way that you have already detailed.

So while Congress labors over how to help those individuals suffering right now, because they did not have the opportunity to plan ahead for their long-term care need, and very likely could not have, as Senator Packwood said, even had they been so prudent as to try to set something aside, it seems to me that even in that setting we can do a great deal to make sure that today's workers, and perhaps even today's independent retirees, do not find themselves in that same very distressing situation as they grow older.

I have seen many interesting proposals which would encourage private insurance companies and employers to offer quality long-term care coverage. The finest idea I have seen thus far has come from the Office of Personnel Management. Senators Dole, Durenberger and I have since drafted and introduced legislation, S. 1738, based on OPM's proposal, and I hope to add other distinguished members of this committee as cosponsors of S. 1738 because it seems to me that it proposes one part of the solution to this problem.

OPM proposes to offer optional nursing home and home health care coverage to Federal employees who want it, and at the same time provide what may very well be a model that can be emulated by General Electric, the University of California, large labor union pension funds. Simply stated, the idea is for a convertibility of group life insurance to prepaid long-term health care.

When a young breadwinner selects among employer-offered benefit options, the kind of security that he hopes for his young family, he or she most likely will buy life insurance, group life insurance determined to provide security to that young family. But once those children have begun to grow up, once they have in fact become largely independent, that same employee, quite reasonably, finding himself confronted with an entirely new set of challenges, finds that he really has no way to deal with those new circumstances at the present time.

Now what we hope for is that the Federal employee who has been enrolled in FEGLI, the Federal Employees Group Life Insurance plan, will be relieved of that worry by having the opportunity to convert some part of the face value what is presently group life insurance to prepaid health care, and, specifically, to up to as much as 3 years of nursing home care.

Once those children have left the nest, and that Federal employee is compelled to worry about his or her own independence in old age, and about becoming a burden to those children, we hope that OPM's plan will allow Federal employees, regardless of their health status, who have reached the age of 50 and participated in the life insurance program for 10 years, to convert their life insurance to long-term care insurance at no additional expense to the Federal Government and at only a very reasonable additional cost to the insured.

Since long-term care insurance cost more than life insurance, the employee would have to pay a small additional premium, which we calculate with actuaries to be about $11 per pay period. But the Federal Government would simply redirect the contribution that it now makes as the employer toward the employee's life insurance to ensure long-term care.

These two sources, plus the reserves in the employee's life insurance fund, would pay for the new benefit and keep premium cost down. OPM would also make coverage available to spouses, although the employee would have to pay the full cost of the premium without an employer contribution.

There is now a pool of over 3 million Federal workers, 3.1 million to be exact, who offer a very tempting incentive for insurance carriers to develop a competitive long-term care insurance program. To date, only about 423,000 long-term care insurance policies have been sold. Ninety percent of Federal employees participate in OPM's life insurance program, and some 655,000 would immediately become eligible when and if S. 1738 became law.

This proposal alone could double the number of people in this country who currently hold long-term care coverage.

Just as importantly, by taking the lead to create a market in this area—and I submit that the market is there and I think your statement this morning, Mr. Chairman, indicate your belief as well that it is—the Federal Government can create a long-term care domino effect. With more insurance carriers entering the market, and with existing programs able to expand to offer competitive services, I think that as a result we will find competition and that the prices, of premiums will fall. And as they fall, if that price reduction occurs, it will presumably make it possible for private companies and for State and local governments to offer a long-term care insurance benefit plan and for individuals to purchase their own private coverage.

Currently, private long-term care insurance does not play a bigger role because most individuals and employers simply cannot afford the high cost of the premiums.

And as two of today's panelists, Alice Rivlin and Joshua Weiner, point out in their excellent new book, "Caring for the Disabled Elderly":

> Group insurance especially geared to the nonelderly population would potentially address the problems of high cost and adverse selection. Premiums should be lower

> in employee-based group policies because . . . people would be able to contribute over their entire working careers, allowing reserves to build.

Plans such as OPM's will make long-term care insurance available to the middle class and take it out of the realm of a benefit available only to the wealthy.

Currently, Congress does not have a concrete understanding of just how far the private sector can go to meet future long-term care needs. It is difficult to decide what role the Federal Government must play in filling the gaps before the private sector has fully defined what it is willing and able to do before it has fully developed its potential.

Mr. Chairman, in your bill, you create a public/private partnership in meeting the Nation's need for long-term care insurance. The vote on the Pepper bill signaled that Congress hesitates this year to move ahead in defining the public side of that partnership. But I believe members are ready to facilitate development of the private partner and afford the private sector the opportunity to define just how large a role that it can and will assume. S. 1738 does just that. The data that will result from increased private sector activity in this area will be invaluable as Congress considers more comprehensive proposals in the future.

Thank you again, Mr. Chairman, for the opportunity to speak on a subject of critical importance, and thank you for your very thoughtful pioneering work. I look forward to working with you to develop a national policy on long-term care. It seems to me that S. 1738 offers a very substantial opportunity to the private sector to respond to a very real need, and thereby perhaps reduce the impact that taxpayers will ultimately have to pay for those who cannot participate in this manner of insuring themselves.

Senator MITCHELL. Well thank you very much, Senator Wilson, for a very thoughtful statement about what I think is a very interesting and thoughtful bill. And I know that all of the members in this committee will seriously consider that as part of the discussion of long-term care insurance. And as you suggest, moving in that area may provide us with data that will help us in establishing a broader policy later. So I am very grateful to you for coming today and for presenting your legislation.

Senator Packwood?

Senator PACKWOOD. No questions.

Senator MITCHELL. No questions. All right. Thank you very much, Senator Wilson.

Senator WILSON. Thank you, sir.

[The prepared statement of Senator Wilson appears in the appendix.]

Senator MITCHELL. I would ask the first panel to take your places at the witness table. Joshua Wiener, Senior Fellow, and Alice Rivlin, Senior Fellow, at the Brookings Institution; Charles Atkins, Commissioner of the Massachusetts Department of Public Welfare, testifying on behalf of the American Public Welfare Association's National Council of State Human Service Administrators; Robert Dobson, Chairman of the Committee on Health, the American Academy of Actuaries; and Richard Curtis, President of the Center for Health Policy Development, and Executive Director of the National Academy for State Health Policy.

And we are pleased to be joined by Senator Heinz, who both as a member of this committee and as a long-time chairman of the Senate Committee on Aging, has been one of the most important contributors to care and protection of America's elderly. So, Senator Heinz, we are pleased to have you here this morning. Do you have a statement you would like to make?

OPENING STATEMENT OF HON. JOHN HEINZ, A U.S. SENATOR FROM PENNSYLVANIA

Senator HEINZ. Mr. Chairman, I would ask unanimous consent that my statement be a part of the record. I look forward to hearing our witnesses this morning. I just want to take a moment to commend you on these hearings and on the legislation that you have introduced as chairman of this subcommittee. A number of us, including myself, are pleased to cosponsor your legislation. We do so in recognition of the fact that this is a subject that is a very serious one for a growing number of people. It is one which has received very little attention except in academic circles over the last 5 or 6 years for several reasons. Probably the most important reason is that for the most part senior citizens, in particular, and their families, in general, generally thought that Medicare covered them for most of their health care needs.

As recently as 1984, the AARP membership, which is in excess of 20 million senior citizens, thought that Medicare would take care of their long-term costs. This, fortunately—I said fortunately—is an attitude that has changed, in part to the discussion of the catastrophic illness legislation where there was a great effort made on all our parts to make clear that Medicare and the catastrophic increment of it—which is only that, an increment of acute care coverage—did not in any way attend to home health care or nursing home care. Second, is the fact that Americans are living longer; that there will be in 20 or 25 years as many Americans over age 80 as there were over 65 when Medicare was enacted roughly 20 some odd years ago, gives us an idea of how our population and its needs is changing. And it is a fact of life that if you are fortunate enough to get up to four score years, let alone four score years and five, that you are a candidate at an increasing rate of risk of the need for nursing home or intensive home health care.

And for those reasons this subject is no longer an academic matter. It is a subject that more and more Americans will be coming face to face with. And the purpose of these hearings is to make sure that we are prepared. And I commend you, Mr. Chairman, for your work in that regard.

Senator MITCHELL. Thank you very much, Senator Heinz.

We will begin with Dr. Wiener and Dr. Rivlin, appropriately enough, since they have just completed a 3-year study published by the Brookings Institution last month entitled "Caring for the Disabled Elderly, Who Will Pay," and who are recognized as two of our Nation's foremost authorities on this subject, both of whom were consulted and whose contributions are reflected in part in S. 2305. I don't want to tie you too closely to it so you can feel free to criticize it. As they say in the foreword to most books, "The advice is yours; the final views are mine." And we now look forward to receiving your views.

I say to you, both of whom have been before many congressional committees and are familiar with the rules, and for the benefit of all other witnesses, under the committee rules, all written statements will be placed in full in the record. In order to encourage and exchange between the members of the committee and the witnesses, we limit oral remarks to 5 minutes per witness. And to assist you in determining that, the panel of lights before me operates just like lights on the road. The green light means keep going; the orange light means slow down; and the red light means stop. So we will begin with Dr. Wiener. Welcome. Are we going to begin with Dr. Rivlin?

Dr. RIVLIN. Actually I get to read the statement and he gets to answer all the hard questions.

Senator MITCHELL. All right.

STATEMENT OF ALICE M. RIVLIN, Ph.D., SENIOR FELLOW, THE BROOKINGS INSTITUTION, WASHINGTON, DC, ACCOMPANIED BY JOSHUA M. WIENER, PH.D., SENIOR FELLOW, THE BROOKINGS INSTITUTION, WASHINGTON, DC

Dr. RIVLIN. Mr. Chairman, we are delighted to be here to assist the committee in any way we can as you tackle this hard issue.

The reasons why long-term care is such a serious issue have been so eloquently stated by you and by the other Senators that I don't think I need to go into them. We have, as you say, just completed this study. We are very pleased to make it available to the committee and to draw on the findings as you consider the bill, S. 2305.

We strongly support the general approach to long-term care financing embodied in S. 2305, especially in two important respects. First, we share the view that long-term care expenses should be recognized as a normal risk of growing old. They should be planned for; they should be insured against.

Second, we believe that solving the problem of financing long-term care will require major efforts of both the public and the private sector. There are those who contend that the private sector can become the dominant form of long-term care financing. Our analysis suggests that this is unlikely. Even with fairly generous assumptions about who would participate and the willingness of insurers to offer policies, private sector approaches are unlikely to be affordable by the majority of the elderly, to finance more than a modest proportion of total nursing home expenditures, and to have more than a small impact on Medicaid expenditures and the number of people who spend down to Medicaid financial eligibility.

At the other end of the political spectrum, there are those who argue that we should have very comprehensive public long-term care, but that also seems unlikely and undesirable, unlikely in the present state of the budget and possibly undesirable for the reasons stated by Senator Packwood.

So S. 2305 reflects a new view which we share: Neither public nor private sectors can be expected to carry the full burden of paying for long-term care. We need to increase the roles of both.

A key element, as the Chairman pointed out, in S. 2305 is a 2-year elimination period before the public program begins to pay for nursing home benefits. On average, this amounts to a $44,000 deductible, and in some areas of the country considerably more than that. Thus, the universal availability and aggressive marketing of inexpensive private long-term care insurance to cover the elimination period is crucial to this approach.

If affordable private insurance is not widely available, many people will continue to impoverish themselves during the elimination period, much as they do under the current system.

The reason for choosing such a long elimination period, of course, is to moderate the size of the incremental taxes necessary to pay for the catastrophic portion of the program.

From the prospective of potential nursing home patients, however, this is a risky strategy. As has been pointed out, only about 2 percent of the elderly have any private long-term care insurance at present. So the crucial question is whether a large majority of the elderly would buy the insurance necessary to cover the 2-year elimination period.

The bill reflects the hope that reducing the time period for which an individual would need private insurance coverage to 2 years would make such insurance more affordable. That is clearly right. Two years of nursing home coverage should be cheaper than, say, 6 years.

Assuming that all the elderly who had at least $10,000 in non-housing assets, and who could afford insurance at 5 percent of their income bought one of the currently available 2-year private insurance policies, then, by 2018, we estimate that perhaps 70 percent of the elderly might have coverage. Given that 72 percent of the elderly currently have some Medicare supplemental insurance coverage, it is unlikely that private long-term care insurance will exceed this level of market penetration.

Now that is a lot, but there are some important caveats to this estimate. The insurance policy that we simulated has limitations to it and making it less limited would make it more expensive.

The Social Security Administration actuaries estimate that a year nursing home insurance policy with a 90-day elimination period, but without the other restrictions that the current policies have, would cost significantly more than the insurance policy that we modeled, and that, therefore, fewer people would be able to afford it.

There we also substantial supply side questions which I will not go into here about whether the insurance industry can get itself together to market these kinds of policies. I think it is an open question. And if one were to move ahead with this kind of bill, there would be other protections that we would suggest, detailed in the statement, to protect the population against being pretty much in the same situation they are in now necessary to impoverish themselves to get down to Medicaid.

Thank you, Mr. Chairman.

[The prepared statement of Drs. Rivlin and Wiener appears in the appendix.]

Senator PACKWOOD. Doctor, thank you. Mr. Atkins.

STATEMENT OF CHARLES ATKINS, COMMISSIONER, MASSACHUSETTS DEPARTMENT OF PUBLIC WELFARE, TESTIFYING ON BEHALF OF THE AMERICAN PUBLIC WELFARE ASSOCIATION'S NATIONAL COUNCIL OF STATE HUMAN SERVICE ADMINISTRATORS, BOSTON, MA

Mr. Atkins. On behalf of my fellow welfare commissioners from across the country I would like to congratulate the committee for the tremendous progress you have made drafting thoughtful legislation to restructure the delivery and financing of long-term care. With demographic projections pointing to a rapidly growing elderly population, it is certain that total long-term care cost will increase dramatically, as you well know, from about $40 billion a year now to as much as $120 billion annually by the year 2020. It is far less certain how we will pay for this care or whether the dollars spent will provide the best quality care and the most appropriate setting.

Your bill would take us a long way towards a system that can control costs and distribute them fairly. It increases the public investment in cost effective community-based care which will generate savings by reducing reliance on more costly nursing homes and hospitals. Equally important, it creates incentives for families and individuals to finance part of their own care, limiting the up front public investment required to generate long-term savings. And perhaps of most import it seeks to relieve some of the burden on Medicaid, allowing Medicaid to do a better job for the low income families and children whom it is primarily responsible for serving.

I have submitted for the record a statement outlining the National Council of State Human Service administrators position on the bill's specific provisions, and I wanted to take this opportunity to share with you our efforts in Massachusetts to invest in affordable cost effective long-term care while at the same time developing alternative financing measures, including long-term care insurance.

This year, the Massachusetts Medicaid program will spend nearly half of our Medicaid budget on institutional long-term care in nursing homes and chronic care hospitals. Medicaid is by far the largest buyer of long-term care, funding some 70 percent of all long-term care beds in the State. If the number of elders grows at projected rates and Medicaid share of cost does not change, Medicaid's liability for nursing home care in Massachusetts could soar to $1.5 billion by the year 2020. To try to slow this enormous potential cost increase, we are developing a new program called "Elderly Choices" that identifies elders at risk of nursing home placement and provides them with community based support. They need to remain at home with lower costs.

Elderly Choices is based upon our experience with the Employment and Training Choices program, known as ET, which we began in October 1983. Through ET we proposed to place 50,000 welfare recipients into jobs and save $150 million over 5 years. Next week, three months ahead of our 5-year plan, Governor Dukakis will announce ET's 50,000 placement. Just for the job placements made through last calendar year, we estimate that after deducting all program costs, ET has saved $132 million in reduced welfare benefits and increased revenue since these former welfare recipients are now taxpayers themselves.

The relevancy of ET to long-term care is that when we first started ET we spent more on the up front investment than we saved. Despite losses in the first year, we were able to win support from our legislature for additional resources in the second year by demonstrating that welfare recipients were getting good jobs through ET and leaving welfare. And by the end of the second year we more than broke even.

It is this kind of investment and savings strategy we are pursuing with Elderly Choices. This new program aims to ensure that elders have access to a wide range of health services provided in their homes or in the community, such as home health private duty nursing and preventive health care. And to coordinate the care and control otherwise fragmented system of community services with many points of entry, Elderly Choices includes centralized in—take offering one package of services, followed by ongoing case management and managed care.

How will a program like Elderly Choices in the legislation before you today save money or at least slow the growth of long-term care cost? In four ways;

One, preventing or delaying expensive nursing home stays which cost, an average of almost $25,000 a year compared to an average of $10,000 or less for most community-based care;

Two, coordinating previously unmanaged community-based care, reducing duplication and inefficient use of services;

Three, risk sharing with providers of community-based services through performance-based contracts just as we developed in our ET program that reimburse providers for services at a flat fee amount for recipients.

And, four, high cost case management. Elderly Choices will be linked with an overall Medicaid effort to identify hospitalized, high-cost patients who may be more appropriately cared for in community-based settings or even at home, again at lower cost.

Mr. Chairman, your committee's leadership in attempting to reform the delivery and financing of long-term care has put the issue squarely in the public spotlight. Since Congress has recently moved to support catastrophic coverage under Medicare, I am hopeful it would also move forward with your bill.

If our experience in Massachusetts with ET and Elderly Choices is any indication, taxpayers will support a plan which can finance itself such as you have proposed, not just from premiums and copayments and other direct revenue measures, but by creating incentives and resources for the growing elderly population to remain in their homes longer and avoid costly nursing home placements.

I believe that better cared for elders and savings like these are critically needed and will be warmly welcomed by the American public. Thank you.

[The prepared statement of Mr. Atkins appears in the appendix.]

Senator MITCHELL. Thank you very much, Mr. Atkins. Mr. Dobson.

STATEMENT OF ROBERT H. DOBSON, CHAIRMAN, COMMITTEE ON HEALTH, AMERICAN ACADEMY OF ACTUARIES, WASHINGTON, DC

Mr. DOBSON. Good morning.

Senator MITCHELL. Good morning.

Mr. DOBSON. I am a consulting actuary employed by Towers Perrin in Jacksonville, FL, but I am speaking here today on behalf of the American Academy of Actuaries whose committee on health I chair.

We are pleased to have the opportunity to participate in these discussions concerning the additional possible public financing of long-term care.

As citizens, we are concerned about the staggering cost and uneven burden of long-term care. We applaud this bill as a beginning of a discussion on this topic.

Since our written comments will be made a part of the record, I am going to limit my oral testimony to only one point taken from the written testimony, and that is this. Health insurance programs, whether they are private or public, affect overall expenditures by their very existence. This is the basic insurance principle that actuaries deal with every day. Medicare is perhaps the best case in point. Of course, this makes cost estimates very difficult, but that is the essence of actuarial science and that is our business.

I think most people recognize the cost will increase for long-term care over time as the proportion of the elderly increase because of advancing medical technology that will allow the elderly to live longer and as the cost inflates. However, what we are really saying is more than that. We are saying by the very existence of an insurance program demands will increase from a couple of factors. One, families will do less perhaps; second, fewer people will do without services that they may need now but cannot afford once public financing is available. At the same time, the supply will increase as the health care industry responds to the additional financing available and devotes more resources towards providing long-term care services.

I am not suggesting that any of that is bad or that anything about this bill would create those effects any more than any other public or private financing of long-term care. All we are really suggesting is that costs will inevitably increase because of additional financing, and we hope the policy makers will keep this in mind as they proceed in the discussion.

We certainly would welcome the opportunity to respond to any questions or to continue to be part of the discussion as you proceed. Thank you.

Senator MITCHELL. Thank you very much, Mr. Dobson. Mr. Curtis, welcome. We look forward to hear from you as well.

[The prepared statement of Mr. Dobson appears in the appendix.]

STATEMENT OF RICHARD E. CURTIS, PRESIDENT, THE CENTER FOR HEALTH POLICY DEVELOPMENT, AND EXECUTIVE DIRECTOR, NATIONAL ACADEMY FOR STATE HEALTH POLICY, WASHINGTON, DC

Mr. CURTIS. Thank you, Mr. Chairman.

In my prepared remarks I focus largely on the potential of State developed case management systems like that alluded to in Massachusetts for long-term care insurance. What can insurers learn from this sad experience; which of those systems might be applicable. You might also want to consider the application of such systems and concepts to the public financing sections of your bill.

As you know, a long-term care insurance market is developing now, but elderly persons do not just want to protect themselves from the cost of extended nursing home stays. They have consistently expressed a strong preference to remain in their own homes if at all possible. Of course, the structure of your bill reflects that preference.

The major question that has been facing insurers, just as the major question that faces you, is how to meet that demand for home-based care in a way that is affordable. Many States over the last decade have wrestled with essentially that issue, and they have designed alternative home- and community-based systems to maintain low income elderly persons in need of long-term care in their own homes. In virtually every instance where a State has successfully implemented such an affordable statewide system, case management has been a critical element. It is used to assess client's needs for care under State guidelines, identify and coordinate the multiple services often needed by frail elderly persons, authorize the amount and type of services that will be covered under an individual plan of care. And this is probably the most important point. It allows the States to make available a broad array of alternative services that can be used to best meet an individual's specific needs and express preferences while controlling the total cost of care.

It was sensible to ask how private insurers might benefit from that State experience, and, in fact, in the State of Washington, the Blue Cross plan has basically bought into the case management structure that was developed under the State's financing system.

Now my testimony briefly alludes to that experience and then further describes the results of a symposium of leading experts from the insurance industry, States and the research community, as they discuss the potential application of those systems.

I think one point that is particularly interesting was the concern over data. There is little or no long-term home care coverage data that would be applicable either to estimating the cost of your program or private insurance coverage just because there have been no such coverage other than a means tested programs like Medicaid. A number of people at that symposium thought it made sense to move forward with a demonstration project now to cover immediately 80 year old and above people and very high risk individuals who we have a better notion of what happens in a social insurance or private insurance context. We just do not know that now.

If you don't mind, I would like to vary a bit from my written testimony and amplify somewhat on a point that Dr. Rivlin and Dr. Wiener alluded to and amplify a bit in their own testimony, and that if you are going to rely on Medicaid in the first couple of years of coverage you are going to need to revise the program somewhat.

Now as you know, it is a very strictly means tested program. It requires people to largely impoverish themselves with the exception now of a spouse at home, which you have largely fixed, and with respect to the household. The point here is that we have explicit policies which require people to basically do away with all the resources that they have saved over a lifetime to become eligible in terms of official policy, but on the other hand, we also allow them to divest as many resources as they want 2 years before becoming eligible. And while there are no numbers available on that, estate planners and attorneys routinely advise people to do that, and in some of the States, particularly Northeastern States, they think that there is a very large problem there.

That could be fixed. You could reinvest some of your savings from Medicaid that results from the second year out and somewhat loosening the severity of these financial eligibility criteria, and at the same time make it more equitable by tightening some of these loopholes. And in addition, you would be helping with respect to development of a private long-term care insurance marketplace because insurers have consistently pointed to that divestiture loophole as the major Medicaid-induced impediments to development of a private long-term care insurance market.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Curtis appears in the appendix.]

Senator MITCHELL. Thank you very much, Mr. Curtis.

Before we proceed to questioning to questioning, I would like to ask Senator Chafee if he cares to make an opening statement. I am pleased that he has been able to join us.

Senator CHAFEE. Well thank you very much, Mr. Chairman. I will just submit it for the record.

Senator MITCHELL. All right.

Senator CHAFEE. And I want to thank you for holding these hearings, the second one.

Senator MITCHELL. Thank you. Then we will begin questioning and proceed in the order in which Senators appeared, and it will be limited to 5 minutes per round. We will continue as long as there are questions.

Mr. Curtis, I begin not with a question but with a request with respect to your last point on improving Medicaid should such a proposal as this legislation be adopted. Would you provide the committee with a specific written suggestion explaining in detail what you said and carrying it further?

Mr. CURTIS. I can amplify on the problem and suggest some alternative policies as a result of it, yes, sir.

Senator MITCHELL. Yes. I wish you would do that.

Mr. Dobson, similarly, you warned against the likelihood of cost increases, something which we are all concerned about, and suggested that persons now needing but not receiving care will receive that care and that families may do less. Those are, I think, common sense suggestions. They are something we all feel intuitively. Are you able to, and if so, will you provide us in writing with some specific estimation of that, some quantification if you can do so?

Mr. DOBSON. I am not sure we can do so on that specific point, but we could certainly use Medicare as an example of how cost increased beyond just increasing the number of the beneficiaries and inflation.

Senator MITCHELL. All right.

Mr. DOBSON. I would be happy to put that together.

Senator MITCHELL. Thank you. If you would do that in writing.

[The information appears in the appendix.]

Senator MITCHELL. Now to Dr. Wiener. In your written testimony you and Dr. Rivlin suggest that one method of decreasing the exclusionary period from 2 years to 1 year would be to increase the copayment level for those who receive benefits after the exclusionary period is over. Are you able to now, and if not, will you provide in writing some estimate of how much the copayment level would have to increase to offset the increased cost resulting from a decrease in the exclusionary period?

Dr. WIENER. I am not able to give an estimate at this time, but I would be happy to provide one.

Senator MITCHELL. All right. We appreciate that.

Second, Dr. Wiener, you mentioned that changes in the tax code should be made so that employers find it more advantageous to help pay for long-term care insurance. Besides those changes already included in the bill, would you provide us with any additional recommendations that you may have to advance that objective?

Dr. WIENER. As I understand it, the bill primarily makes changes designed to clarify the tax treatment of reserves. What we had in mind was more changing of the tax code so that employers could not only contribute to private long-term care insurance but that the build-up of reserves would then not be taxable as well. I think we need to put both acute care retiree health benefits and long-term care retiree health benefits on a prefunded basis, and right now employers face substantial costs if they do that. Some of the restrictions put in place by the Deficit Reduction Act make it difficult to move in that direction.

Senator MITCHELL. And would you suggest if we adopt the concept in the bill that that be permitted for benefits which are intended to fill the gap created by the exclusionary period?

Dr. WIENER. I think that would be a good idea. I think the OPM plan I think could easily be changed to a kind of 2-year deductible period and would fit in nicely with your bill.

Senator MITCHELL. Now you also mention in your testimony that subsidizing the purchase of insurance by lower and moderate income elderly may be a strategy that could make insurance more available for these people. Would you provide us some writing with some specifics in that, in what form, in what amount, how many people would benefit from different levels of subsidies, so that we can then measure it in a more specific way?

Dr. WIENER. I would be glad to do that.

Senator MITCHELL. If you would I would very much appreciate that.

Mr. Atkins, I have got a bunch of questions for you, and since I see my 5 minutes is almost up I will defer to my colleagues and then get to you on my next round.

Mr. Atkins. Certainly.

Senator MITCHELL. Senator Packwood.

Senator PACKWOOD. Dr. Wiener, I was also intrigued with your idea of subsidizing insurance. Are you familiar with President

Nixon's comprehensive health insurance plan of almost a generation ago?

Dr. **Wiener**. I am afraid I am not.

Senator **Packwood**. It was basically the Senator Kennedy mandated plan 10 times over. It mandated employers to provide health insurance. It was not long-term care. It suggested getting rid of Medicaid, privately insuring it, and the Government would pay the premiums on a sliding scale based upon need, which sounds to me sort of what you are talking about in terms of subsidized premiums.

Dr. **Wiener**. That sounds like it would be somewhat similar.

Senator **Packwood**. When you did your investigation, did you find any reason why private insurance has been so long in getting into this field? They have very rapidly over the last 30 years come into the general health insurance field, but why not this field?

Dr. **Wiener**. I think there are several reasons. First of all, the elderly have historically been disproportionately poor; thus, those kinds of financing mechanisms that required a substantial out of pocket cost basically were beyond the financial reach of most elderly. Clearly, the financial position of the elderly has improved substantially in the last 20 years, so it is now plausible to be talking about them making significant financial contributions towards insurance products.

Second—and we are still basically in this problem—insurers have been concerned about moral hazard, a possible increase in——

Senator **Packwood**. Concerned about what?

Dr. **Wiener**. Moral hazard.

Senator **Packwood**. Moral?

Dr. **Wiener**. What in the insurance jargon is called "moral hazard". Basically, as was indicated when people have insurance, when they have to pay less for a product, they tend to buy more of it. It is a traditional conventional economic theory. But we do not have much experience as to how much that increase would be. Much long-term care is provided by the families. Even among the most severely disabled, probably half of them are not in nursing homes, so the potential for increase is substantial.

There is also the potential of adverse selection. And then, finally, I think one point that probably has not gotten enough attention, and if we are going to move in the direction of employer-based products, it needs to be really considered, and that is if you buy a product when you are age 40, you will probably not likely to use the benefits until you are 85. That is 45 years down the road. A lot of water goes under the bridge in 45 years. And the potential for changes in mortality rates, disability rates, use rates, cost of the services, are all enormous, and there is a considerable amount of risk. And the problem that the insurers face is that at age 85 that policy that they sold to that 40 year old, that is basically set, and they are not going to be able to go back and change those premiums to take into account whatever problems they had in setting those premiums originally.

Senator **Packwood**. Out of curiosity, how does that differ from a normal annuity policy when you don't know how long people are going to live 45 years from now?

Dr. **Wiener**. Well I think the problem is basically the same except that you have it compounded by a variety of other things. With an annuity, your basic question is: How long are you going to live? But with long-term care it is how long are you going to live. Disability rates, use rates, the cost of services, all of those things are vastly compounded.

Senator **Packwood**. In your study, if I understand it correctly, you have estimated that private insurance would cover no more than 45 percent of the elderly and pay no more than 12 percent of the nursing home cost. How did you conclude that?

Dr. **Wiener**. Well we built a complicated computer simulation model and made some fairly generous assumptions about how much people would be willing to pay for private insurance, and then looked at the policies and figured out through the computer simulation what proportion of nursing home expenditures they would pay for.

Basically, you have many more people having insurance than you have a proportion nursing home cost paid for two reasons. One, the policies typically have substantial restrictions which limits the degree of financial protection they offer, in particular, prior hospitalization requirements, and policies that are not fully indexed for inflation. And, second, one of the problems we face with long-term care is that there is just a very, very long lead time. The people who are 65 now are going to be with us for the next 20 to 30 years. So it is going to take a long time for that insurance to filter up to the age group most likely to need long-term care.

Senator **Packwood**. When you did your study did you consider the possibility of mandating employer coverage of long-term care? And if not, why not?

Dr. **Wiener**. I can't say we gave it a whole lot of consideration. We tried to look at a wide range of options. I guess I have three or so thoughts about it. One is an employer mandated benefit. Basically, the relatively regressive way of financing the benefit, because everybody would essentially have to pay the same price for the same benefit. One of the things we do in both Social Security and in Medicare is that we actually do a fair amount of income redistribution. It is hard to do that in the private sector.

The second is, again there is a very long lead time. People who, mandating private coverage for a 35 year old may solve his problem, but for the person who is 50 or 60, the costs would still be very substantial for a fully private program.

Senator **Packwood**. Thank you, Mr. Chairman.

Senator **Mitchell**. Senator Heinz.

Senator **Heinz**. Mr. Chairman, thank you.

What I would like to do is ask each one of you in turn to relatively briefly answer the following question, which is, if there was one change that you would like to make, only one change in Senator Mitchell's bill, S. 2305, what would that change be? Now that is the easy part. Here is the hard part of the question. And either how would you pay for that change and/or who should pay for it and why? Mr. Atkins.

Mr. Atkins. I had hoped I was going to get to go last again.

In my testimony, Senator, I have stated for the record four points that I would refer you to on pages 9 and 10 that the National Council of State Human Service Administrators would ask you to look at in terms of the changes, we would like to see in the bill. So I would like to address and answer more to the question of who would pay for this, because, to me, that is the critical issue.

Senator HEINZ. All right. Go ahead.

Mr. Atkins. As I have tried to describe——

Senator HEINZ. I have only got 5 minutes and that means that everybody has only got 25 seconds.

Mr. Atkins. I will be very brief.

As I tried to describe in my statement, we are quite concerned as the people responsible for trying to serve not just the elderly and disabled through the Medicaid program but in a much larger number, poor women and children across this country, that we have the dollars to provide the latter group the health care services that they need. So we are quite encouraged by the efforts that we see in this bill to try and get some of the financing of long-term care services which we totally agree are much needed.

Senator HEINZ. Who should pay for the improvements you favor?

Mr. Atkins. I believe more and more of the people who are using those services ought to pay for their care.

Senator HEINZ. So it should be the elderly age 65 and over?

Mr. Atkins. No. I believe, as I think Josh Wiener has talked about, if we start at a much earlier age with all of us understanding that we are going to have to pay into some system where there is long-term care insurance or some other means of funding through Medicare, that all Americans ought to be paying for the long-term care, not just the elderly.

Senator HEINZ. Is that through general revenues or some other means?

Mr. Atkins. I think it is through a spectrum of means, including the sale of long-term care insurance, the purchase of community care retirement centers and general revenue.

Senator HEINZ. Thank you.

Dr. Rivlin.

Dr. RIVLIN. I think if I had to choose one I would liberalize the Medicaid, existing Medicaid somewhat to make it less onerous. And I think you could pay for that out of what Senator Mitchell's bill would save in Medicaid expenses. I just don't know the exact offset, but it is going to save a substantial amount to Medicaid anyway. And one thing is to figure that out how to use that, and I think the best use is making Medicaid a little less awful.

Senator HEINZ. Dr. Wiener.

Dr. WIENER. I would agree that we should liberalize Medicaid if I were to try to pay for it by further raising the estate tax beyond what Senator Mitchell had proposed.

Dr. RIVLIN. I would not disagree with that.

Senator HEINZ. Mr. Curtis?

Mr. CURTIS. Well I already mentioned that one so I guess I need one more. I get one more. I would substantially expand the range of non-medical home care services covered under the bill, and I would pay for it by doing it through a case management structure in those States that happen to have an extensive system in place. And there are a number. I would use those systems. And it has been demonstrated through those systems that it is quite affordable if there is a case management structure.

Senator HEINZ. If they happen to have a cost effective case management system.

Mr. CURTIS. Right.

Senator HEINZ. Which is not the case in some instances as well.

Mr. CURTIS. That is true. But we know enough to replicate in many other parts of the country.

Senator HEINZ. Mr. Dobson.

Mr. DOBSON. I don't believe we would suggest any specific changes. Our concern is that the overall cost will be larger than what is currently estimated, and that that will be too great of a burden on the elderly; therefore, it will have to fall on the working population in one form or another and that it should be weighed in with other national priorities.

Senator HEINZ. Now, Doctor, then you did suggest reducing the elimination period from 2 years to 1 year, as I recollect: Did you not? You and Dr. Wiener.

Dr. RIVLIN. Yes.

Senator HEINZ. If we were to do that, how would you pay for it?

Dr. RIVLIN. Well we suggest one way in our testimony, which is to raise the copayment for the longer period.

Senator HEINZ. I wasn't quite clear on which period you were thinking of. Is that the period, between the end of year 1 and 2? What period is that?

Dr. WIENER. Basically, we were thinking of people with very long stays by 5 or 6 years. The copayment level currently on the bill is 30 percent. Maybe you could set that somewhat higher, recapture some of those costs.

Senator HEINZ. Starting when, at the second year, the third year?

Dr. WIENER. We would have to——

Senator HEINZ. Somewhere in there.

Dr. WIENER. Somewhere towards the very back end.

Senator HEINZ. All right.

My reaction to that is that you may end up with a situation where you are raising the copayment on people who do not have any resources with which to copay. And you may quickly find that they are on Medicaid, and that what was a savings becomes a cost.

Dr. WIENER. That is a potential.

Senator HEINZ. Mr. Chairman, thank you.

Senator MITCHELL. Senator Heinz, thank you. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman.

I would just like to make a statement, and that is that I feel very strongly that when we are looking at long-term care we have got to think of those who are under 65, that we should not solely restrict this to those who are on Medicare. And that is why I am attracted by what Mr. Atkins said and some of the other also.

People who have chronic illnesses and require this care are not all over 65. Some of them are children. Some of them, of course, have tremendous expenses with no private health insurance. And so the personal savings to the families are just completely absorbed. So I think it is important for the committee and everybody else to bear that group in mind.

And one of the things that worries me is that if we do not include that group, then the sources of potential funding are going to be consumed, so there is nothing left for the children. And that would be very unfortunate in our society.

Dr. Rivlin, in your studies you solely dealt with those who are elderly, didn't you?

Dr. RIVLIN. Yes, we did. But that is not a judgment that there aren't a lot of people with very great need who are under 65.

Senator CHAFEE. And, Mr. Atkins, your testimony shows that concern, recognition likewise.

Mr. Atkins. Yes. We find there are a large number of middle class elderly in Massachusetts who are going on Medicaid and becoming impoverished in order to do so, so that we will pay for their nursing home care, whereas, if we offered them some other alternatives, especially earlier on, perhaps purchasing long-term care insurance or other means to provide for long-term care services, we would in fact free up the money to take care of some of these other needs.

As you know, Governor Dukakis signed into law just 2 months ago a bill in Massachusetts that would provide universal health insurance to all of our citizens, especially the disabled group who, as you say, are often children who are now not covered by insurance because of preexisting conditions and other restrictions. And we are trying to free up the money, at least in Massachusetts, to provide them care.

And I think you are absolutely right, Senator, it is terribly important.

Senator CHAFEE. And the other factor I think we have always got to bear in mind is that we shouldn't always be looking toward nursing homes. We want to keep these people out of institutions, out of nursing homes. Keep them at home and direct as much of the funding for the encouragement toward that direction as possible.

Thank you, Mr. Chairman and thank the panel.

Senator MITCHELL. Mr. Atkins, one of the most difficult questions with which we must deal in this legislation is Senator Heinz' question, one alternative. This is obviously of importance to you, as you suggest in your statement that there is a competition for resources. I wonder if you might, given your national reputation in this field, personally, and you are speaking for a large association, might not devote some more time to that, and give us the best effort that you can make in that regard, in both areas, what you think might result in savings and how you best think we can handle them. What do you think we should do with them?

Mr. Atkins. Thank you very much, Mr. Chairman, for those kind remarks.

Let me try and answer it as you have suggested as the Chair of the Health Care Committee of the National Council of State Human Service Administrators, but perhaps replace it with statistics from Massachusetts.

Senator MITCHELL. But what I want is not just your oral response now. I would like a somewhat more detailed written response later when you have had a chance to think about it.

Mr. Atkins. I would be delighted to follow up.

Senator MITCHELL. And, Mr. Curtis, I would like to have you do the same thing. Go ahead, Mr. Atkins.

[The information appears in the appendix.]

Mr. Atkins. I would very much appreciate that.

Nationally, we believe that if we can by working with some of the ideas you have presented in your bill and you have heard here this morning be able to implement some alternatives for the way we currently finance and deliver long-term care services, that if we can cost avoid, if you will, even 5 percent of that $40 billion a year that we are now spending, that is going to free up obviously a substantial amount of money that we could be devoting to other things.

From the parochial point of view, if you will, of the American Public Welfare Association, we would, in speaking on their behalf, propose that that money be spent on some of the populations that we have been discussing who very much need to get additional services. We are obviously quite pleased, and I did want to take the minute just to thank the members who are here for the vote last night of 93 to 3 of passing that welfare reform legislation, where my fellow welfare commissioners and I are obviously quite excited about that. That will take more resources as we well know. So that would be the first area I would suggest to you that savings that might result from the Medicaid program in addition to paying for some of our other health care needs as we have been discussing, such as the disabled, to use to help those poor women and children get off welfare. We think that is fundamentally important.

Senator MITCHELL. Thank you very much. Thank you all, gentlemen, and Dr. Rivlin. We appreciate very much your testimony.

Senator PACKWOOD. Could I ask Dr. Atkins just one question?

Senator MITCHELL. I am sorry, Senator Packwood.

Senator PACKWOOD. Mr. Atkins, should we—I'll go back to the Nixon plan in 1971—abolish the Medicaid program, fund it through private insurance. The Government pays the premiums on a needs basis. Assuming here you are not going to put any further burden on the poor than you are putting them on now. You are shifting the method of management administration of it. Is that a wise direction or not?

Mr. Atkins. I think it is a very wise concept to keep in mind, to keep the pressure on government to make sure we are running the Medicaid program as efficiently as we can. I was very much taken by your opening remarks about how sometimes government cannot do things very well, including fighting wars. And as a manager of complicated human service programs, I worry about the same problem. And we have actually looked quite closely over the past 5 years that I have been Commissioner of Public Welfare in Massachusetts of the alternative of privatizing, if you will, following the lead of the Federal Government of some of our services like the Medicaid program. And we have actually explored with some insurance companies the notion of perhaps offering as an alternative to a Medicaid card some private health insurance.

I have been convinced by looking at it very carefully over the past 5 years that in fact government can do a better job than the private sector can do of managing health care costs. We have built in a lot of utilization review and cost controls into the Medicaid program in Massachusetts. There are clearly certain areas that the private sector can do better in this field of health care than government can. But I do think it demonstrates an area where, if we put our talents to work, we can in fact manage those resources in the health care field even better than the private sector can do. But it is a very important concept, again, I would say to keep in mind because it will keep the pressure on government to make sure that we are running those services efficiently.

Senator PACKWOOD. Thank you. Thank you, Mr. Chairman.

Senator MITCHELL. Now, gentlemen, and Dr. Rivlin, there may be additional questions submitted in writing by members who are here and members who could not make it this morning. If you receive them, I would appreciate your responding in writing at your earliest convenience.

Thank you all very much. We are very grateful to you and we look forward to working with you.

The next panel includes Mr. Bernard Tresnowski, President, Blue Cross Blue Shield Association; Mr. Bruce Boyd, Vice President, Teachers Insurance and Annuity Association/College Retirement Equities Fund; Miss Gail Shearer, Manager, Policy Analysis, Consumers Union, and Mr. Daniel P. Bourque, Senior Vice President, Voluntary Hospitals of America, testifying on behalf of the U.S. Chamber of Commerce.

Good morning, Miss Shearer, and gentlemen. You all have testified here before and, therefore, are familiar with the committee's rules. We welcome you, look forward to your testimony, and we will begin with Mr. Tresnowski.

STATEMENT OF BERNARD R. TRESNOWSKI, PRESIDENT, BLUE CROSS BLUE SHIELD ASSOCIATION, WASHINGTON, DC

Mr. TRESNOWSKI. Thank you very much, Mr. Chairman. I noticed particularly Senator Packwood's sense of nostalgia this morning. I too had a sense of nostalgia when I walked into this room. I recall sitting here at this table in 1972 when the Senate Finance Committee held an oversight hearing on the Medicare program. I was on a panel sitting next to Sister Irene Kraus, who was then chairman of the American Hospital Association. And she admonished Senator Long for the Government's inability to address the subject of long-term care. It is now 16 years later and here I sit. And I want to say that I think that the recent debate on catastrophic coverage under Medicare highlighted the subject, and I want to congratulate you, Mr. Chairman, and the committee for focusing on this subject.

I think the primary difference today over what has happened over the past 16 years is the concept that is embodied in your bill, and that is what kind of a viable public/private sector relationship can be developed to address this significant question?

The subject in the Blue Cross Blue Shield organization is one of very serious interest for us. We have now got 12 of our member plans who are in the marketplace with long-term care products and two more will be out there very shortly. The range of benefits covered and the role that we at the Association have taken on are enumerated in my written statement.

In preparing for initiatives in this area, we did an extensive amount of market research and actuarial analysis, and what that told us was that the Government had a role to play in order to support the private insurance industry, We have laid that out in our testimony in some detail, but let me just summarize.

We felt it important that the Government clarify that long-term care insurance products be taxed on the same basis as non-cancelable accident and health insurance. And I realize that that is a provision in S. 2305 and we support that. Also that the continued regulatory flexibility at all levels of Government be characteristic of the way we proceed here. I don't want to be misinterpreted on that point because we do not disregard consumer protection. In fact, the Blue Cross Blue Shield Association is very concerned that consumers receive good protection. For this reason, we have recommended that insurers would have to meet certain requirements based on the NAIC model act and regulation in order to qualify for favorable tax treatment.

We also think the Government has a very significant role to play in clarifying for individuals the nature, extent and risks of significant long-term care expense. The catastrophic bill provided that there be an educational program. We think that is an extremely important matter. The public just does not understand what is and what is not available.

And, finally, we believe that the Federal Government should continue to encourage the collection and availability of cost and utilization data on long-term care services. Now that is one of the major deficits for anybody, whether it be the private sector or the Government in taking an initiative in this area.

Whereas, we believe that the private sector can increase significantly the number of people protected under the cost of long-term care, there are certain segments of the population that the private sector will not be able to get to. Individuals already 85 years old—and that segment of the population, as we indicated in our testimony, will triple—people already suffering from chronic illness, as Senator Chafee indicated in his comments; and the low income, generally. These are segments of the population that probably will not be able to qualify for private insurance coverage.

Specifically with respect to S. 2305, as I indicated, we strongly support the section of the bill related to clarification of the tax treatment of long-term care products.

The essential issue before us in this debate is what should be the nature of the public/private relationship, the partnership? And I would pose it in the form of a question. Should there be a Federal entitlement with time and dollar deductibles filled by the private sector, such as you suggest. Or should the public and private sector focus on population segments?

Part of the answer to that question is a very practical consideration of linking private benefits with the Government entitlement program when the Government entitlement program is unpredictable. It is all right now with a Medigap coverage with the Medicare program, but when you are trying to set premiums 20 years ahead of the event, the uncertainty about where the Government is going to go—is it going to be 1 year, 2 years, 3 years—while eligibility requirements change, matching that over a 20-year level premium is going to be a very difficult consideration.

In any case, we very much welcome the opportunity to engage in this debate and to pursue an effective relationship. Thank you, Mr. Chairman.

[The prepared statement of Mr. Tresnowski appears in the appendix.]

Senator MITCHELL. Thank you, Mr. Tresnowski. Mr. Boyd.

STATEMENT OF BRUCE L. BOYD, VICE PRESIDENT, TEACHERS INSURANCE AND ANNUITY ASSOCIATION/COLLEGE RETIREMENT EQUITIES FUND, TESTIFYING ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA, NEW YORK, NY

Mr. BOYD. Good morning, Mr. Chairman and members of the subcommittee. The HIAA is pleased by the interest in finding a solution to the problem of financing long-term care expressed by your subcommittee and the recognition that the private sector can play an important role. And we applaud the introduction of S. 2305. We believe it will serve as a catalyst for further discussion and ultimate consensus on appropriate public/private financing roles. And we welcome the opportunity to speak with you today and we will be pleased to work with you further as you proceed on this important issue.

All here are aware of the problem. Our Nation is aging with the fasted growing segment being age 85 and older. Since there has been little planning for the cost of long-term care, virtually all is being paid either out of pocket or by Medicaid. And not everyone will need long-term care services. Many elderly will never enter a nursing home, and of those who do, about half will stay for more than 90 days.

So long-term care we believe is suited to insurance. It is difficult to predict for any one person. It is relatively infrequent, but potentially very expensive. The cost, when spread across a broad segment of the population, can be relatively small.

While there has been a small market for long-term care insurance for sometime, because of the level of consumer awareness, the lack of relevant data, and regulatory uncertainty, it has been a slow growing market. But I have been amazed by the activity during just the last few years.

More than 80 companies are now writing long-term care insurance, and there are about six to eight available in each and every State, with more than half a million people apparently insured. And the products themselves are changing. Early products tended to be limited, generally covering only nursing home care, and only then after a hospital stay. But the new products offer nursing home and home care often without a prior hospitalization, and some of the newer products do provide protection against the inflationary cost of care.

I think that this trend toward liberal benefits will continue.

The recent introduction of employer-sponsored plans offers the potential to reach people during their working years when premiums are more affordable. It also gives us the opportunity to include dependence.

The enrollment experience today shows an average age of around 40, which is strong evidence that younger people can and will purchase long-term care protection. So we have a young and growing but still small industry.

A few comments on the specifics of S. 2305. There is much in the bill that we endorse. The enhancements to Medicaid; tax clarifications for long-term care insurance; and the coverage of benefits for nursing home, home health and respite care, just to mention a few. However, we do not favor a program which provides benefits based on a specific time period, such as the 2 years contained in the bill for nursing home benefits. We believe that tends to over assist individuals with sufficient resources to pay for their own care and it is inadequate for those who cannot pay for the full exclusionary period.

Most of the insurance being sold today provides benefits for 4 years or longer.

We believe a time period tied to an individual's own resources would be preferable. But public/private partnerships need testing. We do favor projects designed to test the optimum balance of public/private financing before any national program is implemented. We also believe a program should encourage prefunding for care during one's working years rather than relying on funds available during retirement. And there is a need to clarify such things as the coordination of benefit eligibility between public and private programs and who will be responsible for case management.

Let me close by saying that the HIAA believes that the flexibility of private insurance offers the preferred approach to prefunding long-term care for the majority of Americans, providing maximum choices and flexibility to informal care givers. But even if we cannot come to immediate agreement on the optimum mix of public and private financing, I would suggest we can agree on such things as the approximate cost of care, both now and in the future, need for consumer information education and protection; and the importance of informal and community care.

Thank you very much.

[The prepared statement of Mr. Boyd appears in the appendix.]

Senator MITCHELL. Thank you, Mr. Boyd.

A roll call vote is now underway in the Senate, and it will be followed by another immediately thereafter. So we will have a recess which should last approximately 10 to 15 minutes, and we wilt resume with Miss Shearer. I will return as Soon as the second vote gets underway. We will be in recess briefly.

[Whereupon, at 11:05 a.m., the hearing was recessed.]

AFTER RECESS (11:28 a.m.)

Senator PACKWOOD. We will come back to order, please. Mr. Boyd, do I understand we finished your opening statement?

Mr. BOYD. Yes, Senator.

Senator PACKWOOD. Then we will take Miss Shearer next.

STATEMENT OF GAIL E. SHEARER, MANAGER, POLICY ANALYSIS, CONSUMERS UNION, WASHINGTON, DC

Ms. SHEARER. Thank you, Senator Packwood.

Consumers Union appreciates the opportunity to present our views on the Long-Term Care Assistance Act of 1988. We commend Senator Mitchell for his leadership on this important issue.

My testimony today will focus on the role private insurance would play under the Long-Term Care Assistance Act of 1988. The key points are as follows: First, the private long-term care insurance market is not presently meeting consumers' needs and will not do so in the future without substantial government intervention.

Second, there are several very good policy options for improving market performance to enable it to meet consumers' needs.

A key premise of Senator Mitchell's proposed bill is that private insurance will be marketed and purchased more aggressively to protect consumers against the uncovered costs of the first 2 years' nursing home stays.

Consumers Union believes that if Congress chooses to allow the private insurance system to be a major player in the solution to the long-term care problem, then Congress must take unusually strong steps to assure that the private market provides high value products. Neither the unguided free market nor the current National Association of Insurance Commissioners regulations will be sufficient to improve the performance of this market.

In May 1988, *Consumer Reports* published an in-depth evaluation of 53 private long-term care insurance policies. What we found was disappointing. All 53 of the policies we looked at had at least one major flaw. All of the policies were expensive. Some of the key findings of the article are:

People with existing health problems are often denied coverages; the policies are expensive, with premiums for a 65-year-old as much as $100 a month; some policies cover only skilled and intermediate care, and not custodial care—the potentially longest lasting kind of care—many others restrict the benefits for custodial care; while 61 percent of the patients enter a nursing home without being hospitalized, 72 percent of the policies examined required prior hospitalization before any benefit could be provided; few policies had protection against inflation, which can seriously erode the value of the policy over time. Only one company had built-in inflation protection, and less than half offered an optional inflation rider.

Another disconcerting fact about private long-term care insurance is the amount of money that is diverted from the pool of funds available for benefits to pay for the costs of marketing, administration and profits. Forty to 50 percent of premium dollars are expected to go towards these costs.

Another disturbing conclusion one must draw from the *Consumer Reports* article is that the variation in policy options is overwhelming to the average consumer, and denies the consumer the opportunity to compare the merits of alternate policies in a rational and effective way.

For example, daily policy benefits range from $40 to $100, or might be a percent of actual charge, or might vary by level of care. Inflation protection varies. Type of facility included varies. Requirements for prior hospitalization vary.

The degree of variation does not serve consumers well. Consumers are precluded from comparing the prices of similar policies. Too many things vary from one policy to another.

We recognize that budget constraints may force Congress to enact a long-term care program that does not cover all of the long-term care costs. In the interest of providing constructive suggestions, I will outline three options for enabling Congress to significantly improve consumers' "bang for the long-term care buck" without burdening the Federal budget beyond what is proposed in Senator Mitchell's bill.

The first option is a voluntary Medicare Part C. Under this option, the Medicare-eligible could buy voluntarily long-term care protection through the Medicare program in a way similar to Part B. However, unlike Part B protection, 100 percent of the costs of the program would be paid through the premium. There is no question that the premium would be high, but should compare favorably with private insurance premiums since the Medicare program has a solid history of very low administrative costs.

In contrast to the relatively low-efficiency of the private market, Medicare returns 97 percent of revenues collected in the form of benefits.

Premiums could be scaled to income or partly "flat" and partly income-related.

The second option could also have relatively low administrative costs, but could allow for a larger private sector role in implementing the program. Under this approach, the Government could design a standard long-term care policy, with three or four option levels, and would allow private insurance companies to bid for the right to market the policy on behalf of the Government. The companies that would win the right to market the policy would be those that could assure us that they would not divert substantial funds away from the money available to pay benefits.

The third public policy option could provide an even greater role for private insurance companies and is likely to significantly increase the value consumers receive for their long-term care dollars. This option involves standardization.

Under standardization, the Government would establish uniform definitions for key policy terms and restrict the variations allowed for other insurance policy provisions, such as length of waiting period or inclusion of home care.

Policy standardization should be distinguished from minimum standard types of regulation. With minimum standards, insurers are free to offer benefits greater than the minimum standard. This approach has been tried in Massachusetts with Medicare supplement insurance and the results are very encouraging. Thank you.

[The prepared statement of Ms. Shearer appears in the appendix.]

Senator MITCHELL. Thank you, Miss Shearer.

Before hearing from our last witness, I would like to acknowledge the presence of Senator Baucus who has been very much involved and has been interested in the area of health care for the elderly. Senator, do you have a statement you wish to make at this time?

Senator **Baucus**. I have no statement, Mr. Chairman, but I do have a question.

Senator **Mitchell**. Thank you. Then we will hear, finally, from Mr. Bourque. Welcome.

STATEMENT OF DANIEL P. BOURQUE, SENIOR VICE PRESIDENT, VOLUNTARY HOSPITALS OF AMERICA, TESTIFYING ON BEHALF OF THE U.S. CHAMBER OF COMMERCE, WASHINGTON, DC

Mr. **Bourque**. Thank you, Mr. Chairman and members of the committee. I am a senior vice president for Voluntary Hospitals of America, but I am here today as a member of the U.S. Chamber of Commerce Health Care Council, having served earlier as chairman of the HSS Task Force on Long-Term Care Health Policies.

Mr. Chairman, the Chamber applauds you and commends you for continuing the dialogue on long-term care in a sincere effort to find a workable and affordable set of solutions. The need for Congress to address the issue of long-term care I think is indisputable. The realities of our demographics ensure that the problem is only going to grow in the future.

Mr. Chairman, the business community recognizes the serious nature of this issue and that employers have an important role to play in its possible solution. Business, as has been mentioned earlier, has been the backbone of this Nation's private health insurance system and has been a focal point for many health and social issues. But there are many competing interests vying for limited financial resources, the problems of the uninsured, AIDS victims, and other health care issues. Some must set some priorities and sort through all the possible alternatives and finally devise a plan that balances our needs with our resources, both from the public and the private standpoint.

Among the many options which have surfaced thus far to address long-term care financing, the promotion of private financing vehicles, such as long-term care insurance are the most compatible with the Chamber's views. The proliferation of long-term care plans offered by insurance companies and their improved design is a promising sign.

The recent introduction of employer-sponsored plans offers the potential of extending the availability of this protection to millions of Americans. Employer-based plans are an effective means of making this type of coverage readily available, attractive and affordable to large groups of individuals.

A survey by the Washington Business Group on health found that more than half of the companies surveyed—and these are large employers—bad investigated or were planning to investigate the long-term care insurance market within the next 2 years, and many were considering offering a long-term care benefit to their employees and/or their retirees.

Such coverage undoubtedly becomes even more attractive if appropriate tax incentives exist. Federal tax policy could significantly enhance the growth and the breadth of the employer-sponsored long-term care market.

Your proposal, Mr. Chairman, incorporates several important tax changes that will go a long way toward clarifying the tax treatment of private long-term care insurance. The Chamber supports adoption of these tax changes.

Further options could also be considered. For example, employees could be offered the option of directing a portion of their vested retirement benefits, or pension benefits, or their IRA benefits, to the purchase of long-term care insurance.

The Chamber does have reservations about a major new entitlement program at this time. Long-term care is viewed as one facet of a very complex health policy picture. The business community is being faced with a number of concerns in this area—coping with the COBRA changes of 1986, a consideration of mandated health benefits on the general insurance side—and, therefore, has decided to put together a task force to look at all of these issues at what appropriate role the business community can play. And when those considerations are finalized, I am sure they will be happy to bring those forward to this committee. Thank you.

[The prepared statement of Mr. Bourque appears in the appendix.]

Senator MITCHELL. Thank you very much, Mr. Bourque. We appreciate that.

Would you not only provide us with the results of the effort you just described at the conclusion of your remarks but also if you could, after further reflection and consideration, provide us in writing some recommendations on how we could encourage employers to offer long-term care insurance and with two points of view? One, I know you do not support the legislation which would establish an exclusionary period with the Government program picking up the costs thereafter. But I would ask you whether you could not in good faith make suggestions as to how we could encourage employers to offer insurance to meet that gap if we do go with such a program. And in the alternative, if there is no program, just to move in that area generally, if you follow the gist.

Mr. BOURQUE. Yes. I would be pleased to do that.

I would also like to mention that the National Chamber's Foundation, which is a private arm of the Foundation, did put together a task force report 2 years ago on catastrophic and long-term care, and have listed a number of alternatives in here, many of which have been discussed already this morning.

I do want to respond in one way. I think that the efforts that can be made by the Government and others to improve education in this area—that is, the risk of long-term care to the population, and available sources of financing, what the Government's program cover and do not cover, better understanding of Medicaid—will go a long way to improving the employer side, because, frankly, the employers are likely to be more responsive to what their employees' concerns are. And if those concerns are elevated by an awareness of their long-term care risk, then in that bargaining process you will see more pressure being brought to bear on the employers to voluntarily offer this kind of coverage. So I think the education process is extremely important to furthering the availability of these benefits.

Senator MITCHELL. Well thank you very much, Mr. Bourque. As always, your testimony is very helpful, and we look forward to working with you in this area.

Mr. Boyd, I believe that the most reliable predictor of future human behavior is past human behavior. Given the record of private insurance in this field—first, the notable lack of effort and then the description of the policies that exist, given by Miss Shearer, and in a very comprehensive report that is far longer and more detailed than the brief summary she gave here—what can you provide to us in the way of evidence to support the view that we should do nothing in the way of a Government program, that is, a public/private partnership? And that, in essence, as I take your statement, we should adopt the tax changes in the bill, and then leave it up to the private health insurance industry. And I would ask you what can you offer us that would lead us to accept that point of view?

Mr. BOYD. Well perhaps I can answer that in two ways. First of all, using a historical perspective, I would liken long-term care to other insurance in their early periods, such as health insurance. I think when health insurance first came out it provided relatively limited policies. We now have health insurance that covers millions of Americans, largely through employers, and offering very comprehensive coverage.

As to doing nothing, the thrust of what I think we would like to recommend is that there are States that are, doing experiments right now. The Brookings Institution has finished phase 1 of a very impressive study and are launching phase 2. I think we have a lot yet to learn before we implement any broad scale national policy.

I think until we do that, we should concentrate on areas that we all seem to agree on, and one is expanding Medicaid to do a better job of helping the needy. Two is tax incentives to try to encourage a young but developing insurance industry.

Senator MITCHELL. Well there is no doubt we need more information. That is always true. But perhaps the most difficult aspect of those of us who are involved in the establishment of public policy is to determine when the evidence is sufficient to justify action, and when the cost or risk of inaction is higher than the cost or risk of action. We are obviously never going to get to the point where every single fact is known, every single question answerable. And we look forward to working with you. We do have a different point of view, but we certainly appreciate the contributions the industry has made until now, that they will continue to make, and hope that out of this all can come a cooperative effort to deal with what I think we all agree is a serious problem that must be addressed. So I thank you for your comments. Senator Packwood.

Senator PACKWOOD. Bernard, I was intrigued with something you said. That the employers know the needs of their employees on a uniform plan more than perhaps the Federal Government does. I experienced that also when I was bargaining. It wasn't just the employers, it was the unions. It would depend upon the demographics of the union, and whether it was principally male or principally female. But in 1958, 1959, 1960 and 1961, if you were bargaining with the food clerks, as food and commercial workers are now called, the retail clerks—in the food industry they are principally female—and they were very interested in sick leave. It turned out it really wasn't sick leave for them so much as having a sick child or a child that they could not place someplace during the morning, or the baby sitter didn't show up, and they needed to take half a day off. And we called it "sick leave" in the contract, but it was to accommodate a particular demography.

Also in bargaining at the very same time in the very same area with the building trades, it was all male. They were not wild about their wives working in the marketplace. They didn't care about sick leave in the same sense. They weren't going to take care of the child. Their wife was supposed to take care of the child. And you could see the difference in the contracts as to who needed what for the circumstances. That is one of the reasons today that day care is one of the biggest issues in the Nation, is because in many areas we have not taken care of it.

And I want to quote a couple of your statements. "The Chamber believes that to the extent possible the private sector market for long-term care, like health coverage generally, should be encouraged because of the efficiencies of pooling risks and the internal build up of accumulated reserves, insurance provides an efficient means," and whatnot. "Employer-sponsored markets is the most effective way to expand rapidly the availability of long-term care offering this insurance through employment as an effective means." Why not just mandate it as we do social security, as we do workers compensation, and say, you provide it. Here is the minimum level of benefits you have to provide. If you and your employees want to provide beyond that, that is your business. Why not do it like we do workers compensation, and the Federal Government won't be involved in it at all other than the minimum level of benefits? And give you the tax incentives to do it. I am not talking about just mandating it and no offsets on the cost, but why not do it that way?

Mr. TRESNOWSKI. Well I think the business community is trying to come to grips with the mandated aspects of general health insurance.

Senator PACKWOOD. Well they have come to grips with it. They are opposed to it. (Laughter)

Mr. TRESNOWSKI. That is correct, Senator. (Laughter)

What they are trying to do is to propose a series of alternatives, one of which includes trying to shape up existing public programs, like Medicaid, liberalizing the Medicaid program to take care of those who are the least fortunate.

Mandated benefits are a difficult issue for the business community because it is hard to draw the line. You know, which benefits ought to be mandated, which ones should not. Should we start with the uninsured?

Senator PACKWOOD. Let me ask you right now, you are familiar with the theory that employee fringe benefits are really paid for by the employer anyway. They would otherwise pay them the wages, and if they don't pay them that much in wages, I mean pay fringe benefits, they pay that much less in wages.

In my experience in bargaining, that was actually true. When I was sent in by the employers, they would say—you know, again, it was 30 years ago—the most we can pay is $4.80 an hour. That is all we are going to pay. You can divide that up in fringes as you want. You agree with the theory?

Mr. **Tresnowski**. And I think that, you know, we have seen the proliferation of the benefit on the general insurance side. And I think that we are now to the point we are having covered so many people on a voluntary basis with the proper incentives.

Senator **Packwood**. Well if you agree with the theory, here is what I am thinking. In that case, employers are now paying $59 billion a year for Medicare, 1.45 percent on the employee, 1.45 percent on the employer. But if you assume that the employer pays it all, $59 billion, Mr. Tresnowski, what could you do with $59 billion?

Mr. **Tresnowski**. When was that?

Senator **Packwood**. Pardon.

Mr. **Tresnowski**. Which $59 billion was that?

Senator **Packwood**. That we now pay for Medicare. If instead of running it through the Government we had mandated minimum benefits and said to the employer you pay Blue Cross $59 billion a year, could you match what we are doing in Medicare now?

Mr. **Tresnowski**. That is a tough question to answer. It would depend on whether we could do the kinds of things that Medicare has done in terms of provider payment policies and those sorts of things.

Senator **Packwood**. You mean whether or not we kept hands off your cost containment policies.

Mr. **Tresnowski**. That is right.

Senator **Packwood**. Given that, do you think you could do it?

Mr. **Tresnowski**. A categorical answer on that, I don't know. I really don't.

Senator **Packwood**. Now let me ask Miss Shearer. Your 97 percent pay out on Medicare, what is your source of that? I have not seen a figure that high before.

Ms. **Shearer**. It is the Medicare/Medicaid fact books that comes out every now and then and I can provide you the exact cite.

Senator **Packwood**. I would like it. On Social Security I have seen that figure, on the pension benefit. But that is because there is no discretion in the Government, as how old were you? How long did you work? How much did you make? Here's your check. And we computed every year and that's it. But I have never seen that high a percentage on Medicare.

Ms. **Shearer**. Yes. I forget the exact name, but it is a Medicare/ Medicaid fact book put out by the Department of Health and Human Services.

Senator **Packwood**. If you could get me the cite I would appreciate it.

Ms. **Shearer**. I certainly will do that.

[The information appears in the appendix.]

Senator **Packwood**. Now your statement as to 40 to 50 percent cost on insurance for long-term care, in your studies, has Consumers Union found roughly the same type of percentage on general health insurance policies?

Ms. SHEARER. I am not aware of any studies that we have done that address that question. But I am familiar with the Medicare supplement insurance market, which now has average loss ratios of 60 percent for commercial Medigap policies. The variation is very great and some loss ratios are much lower.

Senator PACKWOOD. Can I assume that if it isn't 50 or 60 percent, you would presume that there is some fair percentage of marketing administrative cost in apparently private policies that you think do not adhere in public policies?

Ms. SHEARER. Absolutely. And this is an issue with which this committee should be concerned. It is a major difference between the way the public sector and the private sector——

Senator PACKWOOD. Well in that case—and then I will conclude with this on this round, Mr. Chairman—if that indeed is a fact, why shouldn't we opt for eliminating all private insurance and nationalize it so that we could reduce costs?

Ms. SHEARER. I wouldn't argue with that, but some other people in this room might. I wouldn't argue with that, but some other people on this panel might.

Senator PACKWOOD. You would not argue with that. You would think the Federal Government could do it cheaper if we went to national health insurance.

Ms. SHEARER. I have outlined three proposals in my testimony with varying degrees of involvement for the private sector. One of the proposals would be a voluntary Medicare Part C, 100 percent premium financed, but administered through the Government. There are other ways that you could have a private sector role, but reduce the amount of premiums that goes to administrative cost. But the way we are regulating now—the NAIC model regulation—will not achieve significant savings. We can predict, based on the Medicare supplement insurance experience, that if we continue with the current system we are going to be having loss ratios in the range of 50 to 60 percent if we are lucky.

Senator PACKWOOD. Thank you, Mr. Chairman.

Senator MITCHELL. Senator Packwood, if I could just interject to point out that a recent poll published I believe about a month or two ago show that 67 percent of the American people favor a national health insurance system, but 77 percent of them are opposed to any substantial taxes to pay for it. (Laughter)

That is the difficult part.

Senator PACKWOOD. Well the reason I asked the question is that we used to have an outfit in social security called the Division of Direct Reimbursement. I can see Linda nodding; she remembers it. When we went into Medicare, and we had the intermediary carriers, the argument was they were going to cost us so much and charge us so much that we would be better off to get rid of them and we pay hospital costs directly. And the Government had this Division of Direct Reimbursement. The New York municipal hospitals used them and a couple of others did, where we paid them directly, until the GAO finally did a study of what it cost. Blue Cross of Maryland—and this was a good example to use—would pay a claim as opposed to the Division of Direct Reimbursement, because the Division of Direct Reimbursement was located practically across the street from Blue Cross of Maryland, the same traffic conditions, drew from the same labor pool. The difference was outrageous. And the Division of Direct Reimbursement was finally abolished. It could not match Blue Cross of Maryland by as far as I recall. Like a $12 versus a $4 difference in cost for paying per claim doing the same thing, reimbursing hospitals and providers for Medicare. I do not understand where people come to the conclusion that the Government is a pinnacle of efficiency.

Ms. **Shearer**. I will get you the cite because I think that is very important.

Senator **Packwood**. All right. Thank you, Mr. Chairman.

Senator **Mitchell**. I think the reason for the 97 percent figure is that it is—and is, of course, the principle which underlies the social security system—that the government is the only mechanism by which you can assemble a pool large enough to establish those efficiencies, that is, you get everybody involved. And no single private insurance company can do that.

Senator **Packwood**. That assumes that the absolute be-all and the end-all of the efficiency is the size of the pool, period. And I would be willing to put up a pool of $1.5 million to $2 million against a pool of $20 million and bet you the $20 million is not any more efficiently operated then the $2 million.

Senator **Mitchell**. That may be.

I will just conclude this by saying that at least in my State which borders on Canada, it is not correct to say that people are opposed to a national health system. There is a widespread familiarity with the Canadian system. And while I am personally opposed to a national health system here, a very large number of my constituents do not agree with me on that. They are familiar with the Canadian system. They think it works. They like it. They would prefer it to the system in this country.

Senator Chafee, we have intruded on your time.

Senator **Chafee**. No. I thought it was a very interesting philosophical discussion. (Laughter)

And I wasn't surprised how the sides divided up. (Laughter)

Mr. Tresnowski, I believe it was you in your testimony that said we just don't have much data on this. And I have a feeling that we are going into this business of long-term care for the elderly, which I think is a need, as we all do, that has to be met, without knowing much about what the facts are going to be for the future. Everybody has said the number of people over 85 is going to double between now and the year 2000, 12 years away. All right. But has anybody—and this is a question addressed to the panel—has anybody done any work on keeping people healthy so they will not go into nursing homes? And I am talking of those 80, 85 I mean is there any data that shows if you walk four miles a day you are better off than somebody who does not. Or if you have access to a swimming pool. Or I see data that says if an elderly person has a pet that that person is more likely to remain fit, and alive and alert. And I think these are very, very important points.

I don't think we should just throw up our hands and say everybody is heading for a nursing home and that is the way to go, because I think there should be some data on what happens when an individual stays with his family, or what happens if somebody is in a more temperament climate? Do people over 85 do better in Florida than they do in Minnesota? I don't know. Has anybody got any statistics? And if you don't have it, is there any place where you could direct me to?

Mr. TRESNOWSKI. Mr. Chafee, I would answer that two ways. First of all, I would underscore what you said at the outset about the data. I indicated in my testimony that we had done an actuarial analysis, and, quite candidly, the actuaries came back and said that this is a risk that is really quite unpredictable, There just isn't enough data to know what the nature of the risk is.

Your second question though, as given that fact, what do we know about what it takes to keep people healthy so they don't wind up in long-term care, there really is quite a bit of data on that.

Lifestyle changes, nutrition, exercise, smoking cessation, diet. There is a lot of evidence to show that does promote good health. In fact, the evidence is before us in the changing demographics of our Society. The fact that people are living longer, that people 65, 75 and even 85 are healthy today is a direct result of the changing lifestyle and the kinds of things that happen. However, I would simply point out that it underscores the importance of the subject before this committee, and that is long-term care, because the longer people live, no matter what the reasons are that cause them to live longer, the greater probability there will be for them to need long-term care of some kind. Not nursing home care necessarily, but home health services, respite care, the kinds of things that experts in this business talk about are going to be needed for that population down the road.

Senator CHAFEE. Well I agree with that, except I think you can well have a situation where people will live longer with bad health habits. It is just miserable health, and have to be in some kind of custodial care. So I don't think that necessarily if people have good health habits that that just means they are going to live longer and have the same period of disability at the end. When they are 90 they are going to have 4 years in a nursing home, or wherever it be, because they have remained healthier.

But does anybody else have any contribution? In other words, it seems to me that we should have in any program a preventative factor with some attention being given to keeping these folks healthy and well and out of these places. What have you got to say to that, Mr. Bourque?

Mr. BOURQUE. Well I couldn't agree with you more.

Senator CHAFEE. Everybody agrees with me but nobody does anything about it. (Laughter)

Mr. BOURQUE. Well I think the data is starting to come out on various studies. And again, I cannot cite the sources myself. But you read almost every other day now of new studies indicating what some of these health promotion activities do. It seems to me that if we are going to invest in some research in this area, particularly through the Federal Government, that this might be one of the things that the committee urges the Department to look at more intently.

There is am Office of Health Promotion Disease Prevention, but I don't know whether they have focused on the population over age 65 and those kinds of factors that could be reduced to promote wellness. And I think that that would be money well spent, because we are talking a problem that we are going to be living with.

Senator CHAFEE. This is my point. It seems to me that we accept without argument that we must take care of the elderly with X billion dollars. But if somebody turns around and says, let's put more money into communal facilities for the elderly where they can go and receive a meal at a modest cost 5 days a week with ceramics and whatever it might be in different activities, that is always looked on as a dubious expenditure or one that should be scrutinized carefully. Yet, if we had some facts that would show us the cost savings that comes from having these community centers for the elderly, we might wake up and say that's where we ought to put more money. Bat we don't know, except some kind of empirical evidence that comes around that we think that is right, but we are not sure.

Mr. BOURQUE. This has been the problem under the traditional Medicare program. It has been very difficult to move preventive benefits into the acute care program because no one is quite sure what works and no one is willing to spend the up front money because it does take an investment in order for the potential savings down the road. In fact, it was always amusing to me that the actuaries would always say that it would cost money because you are adding years of life. So every time you promoted a preventive benefit, it ended up being a cost item rather than a savings item, which always baffled me.

Senator CHAFEE. That's a ghoulish way to approach it. (Laughter) Thank you, Mr. chairman.

Senator MITCHELL. Thank you. The representatives of the actuaries in the audience laughed loudest at that suggestion, Senator Chafee. Senator Baucus.

OPENING STATEMENT OF HON. MAX BAUCUS A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you, Mr. Chairman.

I would like to ask the panelists where they agree on the basic questions of what the public/private mix should be in providing long-term care. It is clear to me that this Congress next year will enact a fairly comprehensive bill. It is also clear that the American people regard this as probably the major health issue this year and next. And it is equally clear that we are going to have to answer the basic question of what the mix should be between how much insurance is provided by the private sector, and how much by the public.

You all represent different points of view, but we are going to have to agree on a bill. It will not be four different bills passed by the Congress.

So I would like to know where you agree; not where you disagree but where you agree. What should that mix be, roughly? And just give us idea of where you tend to agree. Mr. Bourque.

Mr. BOURQUE. I think from the Chamber's standpoint, Senator Baucus, if public resources are to be invested in this area—and I think that most people agree that there is a strong push for that to happen and is likely to happen—it probably ought to be in improving the Medicaid program, improving the program for those who are most disadvantaged, and making changes in that program that would perhaps reform the current method of financing and the kind of impoverishment that takes place in order to be eligible for that program.

Senator BAUCUS. That is low income though. What about the bulk of America?

Mr. BOURQUE. I think that is where it becomes more difficult. And I do know that a number of the States are playing with this public/private mix in terms of insurance. And I think that those are very valuable demonstration and we need to learn from that. But I am not sure that anyone is comfortable yet as to how those things can intersect.

Senator BAUCUS. I am not asking whether they are comfortable yet. What might be some of the public programs that you think might make sense of long-term health care for middle income Americans?

Mr. BOURQUE. Well it is clearly going to cost money to support tax incentives and any kind of premium subsidy. If we want the private market to proliferate in terms of financing vehicles, it is going to take a public investment. And I would think that that might be a place to start, as well as mentioning the Medicaid reform. But beyond that, I am not sure we have any other solution.

Senator BAUCUS. Mr. Tresnowski?

Mr. TRESNOWSKI. You said when you asked the question that we each represent a point of view. I represent six points of view. Because this subject is not clear in the minds of people. It is so new in terms of your insurance principle involved that the debate still rages internally. For example, there are those in my organization who are quite concerned about the insurability of the risk at all. And we would be very supportive of defining the risk along the lines of S. 2305, whereby you have a 2-year period and it is fairly well defined. There are some technical problems with that which I mentioned earlier, but there are those who feel that way.

There are others who feel, on the other hand, that we need some time to take the products that we have got into the narketplace today that we have just begun with, and find out whether in fact those products can be insurable. And so they would argue let's not immediately make a decision to go to an entitlement program and eliminate the private sector. Let's buy some time to find out whether it can be done.

So that the debate is really very much in front of us. Nobody knows exactly what is to be done. I cannot sit here today and tell you that don't do anything because Blue Cross and Blue Shield is going to solve the problem of long-term care in this country. I would not do that because that is not what is going to happen. Alice Rivlin said that when she reported on her study and that is true. But there is a role for the private sector. What precisely that is is something that we are going to have to look at very carefully over the next year or two and figure out how we can match up appropriately between the private initiative and the Government.

Senator BAUCUS. All right. But how far do you think we should go in addressing the public sector side of it? Where do you think we are going to end up?

Mr. TRESNOWSKI. Well you are either going to end up with an entitlement program with some kind of a front end with either years or dollar deductibles, or the Government is going to carve out population segments, either the old-old or the poor or the chronically ill, and allow the other segments of the population to-move in and take care of the other.

I think there is a lesson to be learned here from the Medicare program and, more particularly, with the recently passed catastrophic bill. If you trace the history of the Medicare program and catastrophic and the privacy sector's lap filling around those, you begin to understand that there is not an absolute answer. It is kind of an evolutionary thing. People said that when catastrophic passed the private sector is out of the Medigap business. Well that is not true. In fact, it offered a number of opportunities for us.

Senator BAUCUS. That is true. That is right. My time is about up. If I could ask, Mr. Chairman, a couple of more questions just very briefly.

Ms. Shearer, doesn't the private sector have an important role to play in long-term health care?

Ms. SHEARER. Consumers Union favors a public social insurance approach, and if there are any gaps left, let the private sector fill them. We do not support the private sector being the major actor.

Senator BAUCUS. I know that you do not support it, but where are you coming together? Are you saying you aren't agreeing at all?

Ms. SHEARER. There is little agreement here. I think that if there is going to be a major private sector role it is very important for Congress to play a major role in improving the way the private sector is working. I think that we made a big mistake in Medicare when we let the Medicare supplement insurance market, as you know, evolve. We have tried to regulate it for 20 years. We are still not doing a very good job. And we don't want that to be the model for a supplemental market for long-term care insurance. And we feel that it is very important for Congress to address this now.

Senator BAUCUS. Mr. Boyd, how far would you go in advocating a larger public sector?

Mr. BOYD. Well not surprisingly. I think we are more in line with Mr. Bourque. I think we do feel——

Senator BAUCUS. Well I know that. (Laughter)

But I would like to know more where we tend to agree so we can come together here, so we are not spending too much time fighting among ourselves but get something passed and get on with it.

Mr. BOYD. Well I would, and it would be repetitive. I would repeat I think an expansion of Medicaid to better cover those who must rely on it is in order.

Senator BAUCUS. How about average income Americans?

Mr. BOYD. I think there that I would probably divide the problem in two, those who are currently quite old and those who are not. I think people who are currently working, who are currently aware of the problem and for which we are building insurance products, I think they should provide for their own long-term care cost. I think for people who are currently much older, they don't have that opportunity, and I would say that would be an area of concentration for the public sector.

Senator BAUCUS. Well I urge all of us to put ourselves in the other guy's shoes a little bit so we do tend to come together. We in this country spend too much time fighting among ourselves. We tend to think the world revolves around Americans. Meanwhile, other countries, within their own borders, often tend to work better together. And I suggest that all of us just try to put ourselves in the other guy's shoes to better understand his point of view so that we find agreement more quickly than we would otherwise. Thank you, Mr. Chairman.

Senator MITCHELL. Thank you, Senator Baucus.

I will submit additional questions to each of you in writing and ask that you respond in writing at your earliest convenience.

[The questions appear in the appendix.]

Senator MITCHELL. Senator Packwood has additional questions for members of the panel now.

Senator PACKWOOD. It will just take me about 5 minutes.

Mr. Tresnowski, Blue Cross Blue Shield would sell health insurance policies in competition with Mr. Boyd's association, correct?

Mr. TRESNOWSKI. Yes, indeed.

Senator PACKWOOD. Yes. And it would do so rather significantly. Now I want to ask the two of you a question. I am going to leave out Mr. Bourque because he has already come to grips with this issue about mandating. From your standpoint—let's take Senator Mitchell's bill. You have got a 2-year hiatus—if we were to add to it a mandate on employers, that, they would somehow have to reasonably cover that 2 years—we would put down whatever the minimum benefits are, and leave some discretion among different kinds of industries because the needs are not the same in each kind of industry—and say, all right, Mr. and Mrs. Employer, you have got to provide this, why wouldn't that be a benefit to you and Mr. Boyd's association because now it is going to give you an immense pool and you are going to have to compete for it to provide the benefits. Why wouldn't Blue Cross Blue Shield and Mr. Boyd's organization, why wouldn't HIAA support that?

Mr. TRESNOWSKI. Well let me say that the same principle applies to whether you are talking about mandating long-term care insurance or whether you are talking about mandating health benefits in general.

On the surface it is very attractive to us. In terms of the uninsured, you are talking about $23 billion of new money. That is a tremendous thing. But you have got to get past what appears to be a very favorable initiative from our standpoint.

There are a couple of things you have to look at beyond that. One is, what kinds of incentives do you set in motion as a result of the mandate? In fact, do you create a counterproductive initiative to employers in order to get out from under these mandates, do all kinds of crazy things like put people on part-time status, not hire people who are high risks, and on and on and on. That is one real concern we would have about the mandate. I am not saying I oppose it, but in designing such a mandate you would want to design it in a way that you do not create those kinds of incentives.

The second concern we have is that, you know, it is like the old phase, I am here from the Government; I am here to help you. And as soon as the Government comes into the program, what do they do to redesign the insurance market? One of the concerns we have about Senator Kennedy's bill is that he would regionalize the delivery of health benefits to regional insurance carriers. Well that presents a very significant problem for us. One, there would be cross subsidization among States. Our ability to respond effectively under those circumstances, in other words, the regulatory structure that flows with that may be such that it would be so onerous that it in fact would be counterproductive to our involvement in it.

Now all of that is against the backdrop of saying to you that mandates may be a perfectly good solution to this problem. A lot depends on how it is designed.

Senator PACKWOOD. Mr. Boyd?

Mr. BOYD. Our own association is made up of probably a much more heterogeneous group of members than is Blue Cross Blue Shield.

Mr. TRESNOWSKI. Don't count on it. (Laughter)

Mr. BOYD. I think there are those, and at the extreme, people who specialize in reinsurance, for instance, and who do specialize in insuring long-term risks. For them, I think this would not be a very attractive time period, the 2 years. They would probably prefer something up front and insure the longer-term.

I think some of the other membership would indeed react to that, and probably would develop products to fill in the 2-year period. I think all——

Senator PACKWOOD. Well let me interrupt. For those of your members who do not want to do it, they don't have to sell it if it is to be mandated.

Mr. BOYD. I am just trying to—that is true. I am just trying to respond from a broader perspective than maybe my own.

The second point I would make is I think that all would fear that that 2-year period would change over time. And I think all insurers would be a little nervous about jumping into a product development and spending the resources to develop and market a product where the environment may change. And I think that is especially true with what has happened to other Government benefits. So I think there would be some reticence in developing products to get into a time period.

Senator MITCHELL. May I interrupt for one more question?

Mr. Boyd, why would that not be the case now with respect to long-term care generally? On the one hand, you oppose any legislation and say that the industry will develop polices in the field. But with respect to the 2-year period, you say we may be retarded in developing policies because the Government may act to change it. But that principle applies with even greater force to action in the area generally.

It seems to me you are making two diametrically arguments to fend off the different points of view.

Mr. BOYD. I would say it does apply to some extent now. But I do think that with—right now I think companies are looking at the opportunity to develop fairly differentiated and broad policies. And most of them, as I mentioned, are providing policies of 4 to 6 years duration. Some longer.

I think as you compress that, I think people are going to look at this as a much more limited opportunity, and I think, no matter which way it goes, there will be some fear of a Government program. But if you walk us into a 2-year gap, knowing that is there, I think it is just a much more limited opportunity.

Senator MITCHELL. Well I would just say to you that political realities are such, it seems to me indisputable, that the likelihood of some action in the first instance to deal with the problem generally is much more likely than action to change a 2-year period once that has been established.

Mr. BOYD. My reaction is that, sir, is I think that we would like to be very much part of the dialogue in trying to develop the appropriate relationship.

Senator MITCHELL. Yes. And you are. That is why we invited you here today.

Mr. BOYD. Yes. And I appreciate it.

Senator MITCHELL. And we look forward to working with you. I didn't mean to interrupt you, Senator Packwood. I wanted to make that point.

Senator PACKWOOD. No. I was through.

Senator MITCHELL. Well I want to say that we are very grateful to you all. It is obvious there are different points of view. Each of you have represented a different point of view here. It is a very serious problem, a very difficult one.

I repeat what I said at the outset of the first hearing. I am convinced that the problem is of sufficient scope and importance that there will be some action. I recognize that many of you represented here at the witness table and in the audience prefer that nothing occur. But I invite you, notwithstanding your preference, to cooperate with us in doing the best job possible to serve what is our common objective and that is to see that all Americans can enjoy the benefits of the longer lives they are leading and live those last years with some degree of dignity and self-respect. And we all have to remember, we hope to be there someday ourselves

Thank you all very much. Thank you, Senator Packwood, for your contribution.

[Whereupon, 12:17 p.m., the hearing was concluded.]

APPENDIX

Alphabetical List and Material Submitted

TESTIMONY OF CHARLES M. ATKINS, COMMISSIONER
MASSACHUSETTS DEPARTMENT OF PUBLIC WELFARE
and
CHAIRMAN, HEALTH CARE COMMITTEE
NATIONAL COUNCIL OF STATE HUMAN SERVICE ADMINISTRATORS
AMERICAN PUBLIC WELFARE ASSOCIATION

My name is Charles Atkins and I am Commissioner of the Massachusetts Department of Public Welfare. I am here today in my capacity as Chair of the Health Care Committee of the National Council of State Human Service Administrators, of the American Public Welfare Association (APWA), which is comprised of welfare commissioners from around the country.

WELFARE AND HEALTH CARE REFORMS:

Three years ago APWA called for a major reevaluation of public commitments to poor children and their families. We issued a report, "One Child in Four," in November, 1986, recommending sweeping reform of the nation's welfare system. We view welfare reform as critical to our efforts to reduce poverty by strengthening families and promoting self-sufficiency. The governors and members of the Senate Finance Subcommittee on Health have played a major role in the current debate. We would like to commend you, Senator Mitchell, for your leadership on welfare reform and for your strong support for the WIN program. It has been the successes of WIN demonstration programs including our Employment and Training (ET) Choices program in Massachusetts that has shown us we can effectively use our welfare system to promote individual self-sufficiency.

Welfare reform is, as I said, an important step toward reducing poverty in this country. For those on welfare to achieve self-sufficiency and independence they must also have access to health care. APWA plans to issue a report on providing access to health care for the poor and uninsured and to propose how to reform the long term care system.

While it is generally assumed from a public policy perspective that more can be done to provide better long term care services, it is also true that there are limits to the public funds available for such care. Costs of providing the social and medical services required for long term care have increased in recent years, due in part to a growth in the number of people eligible for services and the rising costs of health care in general. A national strategy, involving all levels of government and the private sector, is needed to meet the needs of our citizens for long term health care coverage.

APWA and the National Council of State Human Service Administrators commend the committee's continuing interest and efforts on the issue of health care in general, and long term care financing reform in particular.

THE NEED FOR LONG TERM CARE FINANCING REFORM:

Long term care, particularly the financing of long term care, is a critical issue for state human service Commissioners for two reasons. We are concerned that the elderly and disabled have access to long term care services without facing the possibility of financial ruin. Even more directly, given our responsibility for the Medicaid program, we are concerned that an increasing proportion of public funds dedicated to health care for poor women and children are being used to provide long term care services.

Let me be even more specific, as Commissioner of the Massachusetts Department of Public Welfare, I manage an agency with an annual budget over $2.5 billion that has responsibility for administering cash assistance programs for the poor, as well as for the Medicaid program. This year we will spend in excess of $700 million on long term care services -- roughly half of our entire Medicaid budget. That is more than 20 percent of what we will spend on AFDC -- our key cash benefit program for poor women and children.

You have previously heard testimony on the sobering demographic facts of the rapid growth of the elderly population in our society. While more resources are required to meet the needs of this group, poor women and children have faced a real decline in benefits since many states have not been able to adjust their eligibility limits or cash payments to meet increases in the cost of living. This drastic imbalance in our national method of financing long term care presents a very real dilemma -- we must either reduce state budgets intended for poor children and families, or place an intolerable financial burden on the elderly who require long term care services.

Nationwide, the Medicaid program finances nearly half of the roughly $25 billion spent annually on nursing homes for the elderly and disabled. The rest of the enormous costs, with few exceptions, are met by individuals who use these services and their families, at an average cost of $25,000 a year. If these elderly are not poor when they enter a nursing home, they unfortunately may become so shortly thereafter.

The role of Medicaid in the financing of long term care has developed over the years. Medicaid was not originally designed for this purpose and this large role has placed strains on the program to meet its original mission. We believe that if the country is going to review the financing of long term care, it should review the role of Medicaid and seek to put the program back on its original course -- primary and acute care for the disadvantaged.

We in government must be able to provide care to our most vulnerable citizens. But poor women and children should not be put in the position of having to compete with the elderly for vital services that they depend upon for their health and well-being.

GOALS FOR LONG TERM CARE REFORM:

As I have testified previously before this Committee, APWA and the National Council of State Human Service Administrators believe that reform of the long term care financing system should seek to achieve certain goals, including:

- enhancing the private sector long term care insurance market and products.
- developing a private/public long term care financing mix.
- promoting self-sufficiency and independence among the elderly in need of care by eliminating the current institutional bias of long term care financing and service arrangements.
- providing for client choice among medical and social services that will meet individual needs.
- relieving the financial stress on Medicaid programs so that more funds can be dedicated to acute and preventive services for poor children and their families.

In order to adopt appropriate reform, we must recognize that the Medicaid program now serves as the safety net for many of those who face chronic or disabling conditions. This includes many of the elderly, most of whom are unaware that they will be dependent for their long term care needs not upon the Social Security System or Medicare -- into which they have paid during their working lives -- but upon Medicaid for long term care. We need new financing methods that will remove most of the long term care expenditures from Medicaid so that these funds do not compete with the needs of poor women and children. We need to assure that state and local administrators have the flexibility to provide cost-effective and high quality health care to all families and children in need.

To try and slow the enormous potential growth to Medicaid costs in Massachusetts, and to improve our ability to provide the elderly with affordable care and alternatives to costly institutional placement, we have begun to design a new program called Elderly Choices. This new program emphasizes many of the same features that have made our Employment and Training (ET) Choices program so successful: aggressive marketing, comprehensive case management, client choices, and performance based contracts with the private sector. Through improving the coordination of current services and employing case management services, Elderly Choices will ensure that elders have access to a wide range of services provided in home or community settings, such as home health, private duty nursing and preventive health care. Institutional care will be available, when needed, to those who to need such care. The Elderly Choices program will also pursue selective performance based contracting with nursing homes.

This new approach to managing the long term care system will enable more elders to live independently and provide better alternatives to institutionalization. It will enable us to offer long term care services at less cost than our current limited service options: primarily institutional care in nursing homes or chronic care hospitals.

At a national level, we believe that the government and public would be best served by the development of private long term care insurance and the sharing of public and private funding arrangements. Long term care policy must include a comprehensive plan to finance the effort adequately. It must target feasible, available financial resources, creating an on-going funding mechanism that will provide equal access to benefits for all eligible persons.

THE LONG TERM CARE ASSISTANCE ACT:

We are greatly encouraged by the variety of proposals being introduced this year to address the long term care needs of our society. The Long Term Care Assistance Act, S.2305, plays an important role in translating ideas and suggestions into legislation. Other proposals put forth this year concerning aspects of long term health care have also focused attention on the need for reform, including Senator Kennedy's LIFECARE proposal.

I am pleased that S. 2305 meets many of the goals that human service Commissioners believe are critical to long term care reform legislation. This legislation, in our view, takes a critical first step toward addressing this country's urgent need for development of a long term care policy by offering an array of medical and social services -- from occasional assistance in home settings to complete institutionalization -- along with recommendations for funding the undertaking. Certain aspects of this bill parallel the goals of APWA including:

- emphasizing client choice, based on need and preference, of social and medical services provided through both public and private programs;
- maintaining the self-sufficiency and independence of elders, while recognizing the need for respite care and supportive services for informal caregivers;
- employing a uniform eligibility assessment and certification process, with responsibility for conducting assessment resting with the states, or independent organizations that will not benefit from placement decisions;
- requiring case management for all benefits, ensuring that all appropriate, available care is provided in the least restrictive setting. This enables us to use the most cost-effective approach in meeting the diverse needs of elderly and disabled clients;

- fostering development of private insurance products for long term care as a partial solution to financing community-based and institutional care.
- promoting a public/private sector partnership for sharing the costs of long term care services.

AREAS OF CONCERN:

While the Long Term Care Assistance Act satisfies many of the goals of APWA for long term care financing reform, there are some aspects of the bill that raise questions and concerns for the states, primarily related to the possible fiscal impact on the Medicaid program.

We believe that S. 2305 would benefit from a close look at the impact of this legislation on state revenues and the implications for other populations currently served by Medicaid.

There will undoubtedly be relief for the Medicaid system through Medicare coverage of extended nursing home stays. While these extended stays are not the norm, they do consume a significant portion of Medicaid funds. However, other provisions of the bill would prolong, and likely increase, the long term care financing burden on state Medicaid programs which now struggle to provide services to address the unmet needs of poor families. We find troubling the provision that would limit the use of any realized Medicaid savings by stipulating that states maintain current funding levels for elderly services. We would propose instead that states be permitted to rededicate those funds for expanded services to poor children and their families -- a population in great need of acute and preventive care, as this Committee well knows.

We also do not believe the legislation sufficiently recognizes that many states have been developing effective long term care strategies and have structures in place to administer programs.

Finally, it is important in our view to point out that many of the Medicaid savings assumed by the bill may not be realized. Several factors undercut the savings assumptions.

o **Lack of Affordable Private Coverage** -- The recently released Brookings Institution study estimates that only about 30 percent of the elderly population will be able to afford long term care coverage in future years. This low percentage concerns us. The Brookings projection is based on the assumption that long term care costs will increase significantly over time while the fixed incomes of the elderly -- particularly the incomes of the very old who are most in need of long term care services-- will not grow commensurately. This disparity between income and costs is likely to pose a significant burden on Medicaid.

o **Nursing Home Costs** -- Expanded Medicare coverage for nursing home care, as the bill proposes, is important. However, it is unclear to what degree the Medicaid financing burden will be eased by this expansion. The two-year exclusionary period contained in this bill, together with the fact that the median nursing home stay among current residents is slightly less than 21 months, indicates that many people may not benefit from the services provided in the legislation.

o **Underserved Individuals** -- It is widely believed that significant numbers of people living in the community who need long term care services do not currently receive such services through either Medicare or Medicaid. It can be assumed that many more elderly will become eligible for home health and respite care based on both the more flexible Medicare eligibility criteria and expanded services included in the bill and the expected elderly population growth. Many of those newly eligible for services will likely be low-income which would result in higher Medicaid expenditures.

o **Premiums and Deductibles --** Medicaid would cover the costs of additional premiums, deductibles and coinsurance for the dually eligible under this bill. Medicaid expenditures will increase as these costs are added on. Even the minimal increases in premiums will have an effect when spread over a large population.

CONCLUSION:

Mr. Chairman, the underlying issue in my remarks is that, for the most part, the elderly and disabled, with the support of their families and friends, want to live independently in the community or to live with dignity in an institution when no other option is appropriate.

We encourage your efforts to structure new benefits and programs that empower the elderly to obtain help where they want it and when they need it rather than spending too much money for institutional care that might have been avoided or postponed. We welcome further efforts to affirm government's commitment to long term care by encouraging new financing mechanisms that could slow the growth of these expenditures within Medicaid budgets and permit us to better serve the health care needs of poor families and children.

The APWA hopes you will consider the issues we have raised. This committee has, on previous occasions, acknowledged the importance of developing sound and responsible long term care policy because it will be in place for years to come. Great care must be taken to develop and implement long term care financing reforms. We support this Committee's effort to further the debate and hope to be of assistance in seeking solutions to the problem.

Thank you for the opportunity to present these views today.

APWA

NATIONAL COUNCIL OF STATE HUMAN SERVICE ADMINISTRATORS

July 22, 1988

The Honorable George Mitchell
Finance Subcommittee on Health
United States Senate
Russell Senate Office Building, SR-176
Washington, D.C. 20510

Dear Senator Mitchell:

The attached information is in response to your request at the June 17, 1988 hearing on the Long Term Care Assistance Act of 1988. At the hearing you asked that I respond for the American Public Welfare Association's (APWA's) National Council of State Human Service Administrators on how best to use any potential Medicaid savings that would result from enactment of S.2305. These recommendations are attached.

The APWA believes that states need some relief from the costs of providing long term care for the elderly and disabled. These costs place a significant strain on the Medicaid program and states' ability to provide services and coverage for other populations in need. We believe that states should have the flexibility to redirect any savings to other areas of need, as identified by each state.

The APWA supports the concept of long term care financing reform. We have established a task force which is expected to make recommendations about such reform in the near future. The APWA supports and appreciates your continuing interest, and effort, in this area. If you have any questions, please call me, or have your staff call Jane Horvath at APWA.

Sincerely,

Charles M. Atkins
Chair, NCSHSA Health Care
Committee, and
Commissioner
Massachusetts Department
of Public Welfare

CMA:st
cc: Robert Crittenden

An affiliate of the American Public Welfare Association
1125 Fifteenth Street, N.W., Suite 300, Washington, D.C. 20005 (202) 293-7550

Uses of Potential Medicaid Savings:

Rather than require states to continue to fund long term care services for the elderly at current levels, states should be afforded the flexibility to redirect funds to other populations whose needs have gone underserved or unserved and to other purposes. Alternative uses of these funds include:

Financing Welfare Reform -- Successful reform of the welfare system will require substantially greater funding than is currently available. Potential Medicaid savings could be used by states to extend the Medicaid transitional coverage.

Extended Medical Assistance Eligibility -- Any long term care savings could be redirected to allow more states to cover infants and pregnant women up to 185 percent of the federal poverty level. Only about eight states currently employ this option while many of the others are limited in their ability to do so. State Medicaid savings could also be put toward extending medical assistance eligibility to older children and youth. Many states would like to have funding to provide better outreach for medical assistance, such as placing eligibility workers at provider sites but they currently are limited by inadequate funding.

Amount of Medicaid Savings:

The National Council of State Human Service Administrators is concerned about how great the savings to state Medicaid funds would be under this bill. There are two major considerations.

Increased Demand for Home and Community-Based Care -- There would be greater financial access to home and community-based care services under S. 2305. Recent data indicates that some 19 percent of the elderly population are functionally impaired and live in the community. Of this impaired population living in community, only 15 percent currently receive any public assistance or services. The potential new demand for covered services may be great. The deductibles and coinsurance for the low-income elderly who become eligible for services may cause significant Medicaid cost increases in some states.

Nursing Home Care -- The two year exclusionary period as contained in S.2305, may not reduce the Medicaid burden significantly. The median length of stay among current nursing home residents is slightly less than 21 months. The burden on Medicaid for such services will most likely continue to grow as the elderly population increases. The people currently most in need of extended nursing care are the very old who, concurrently, are without the resources to support the cost of this care. In the future, it is this population who most likely will not be able to afford private long term care insurance.

Administrative Issues:

The administrative issues involved in determining the amount of state expenditures for long term care services for the elderly may prove very complex. The difficulty in this determination for purposes of recouping savings may prove detrimental to some states if the calculations are not accurate.

STATEMENT OF ROBERT M. BALL

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

My name is Robert Ball. I was Commissioner of Social Security from 1962 to 1973 including a time when the Social Security Administration had responsibility for Medicare as well as for the cash benefit program, Old-Age, Survivors and Disability Insurance (OASDI). I was a career employee of the Social Security Administration for some twenty years before I was appointed Commissioner. More recently, I was a member of the President's National Commission on Social Security Reform, the Greenspan Commission, whose recommendations resulted in the 1983 Amendments and restored the financial soundness of the Social Security program.

I am pleased that the Committee has asked me to testify on this subject since I believe that improvements in the quality and availability of long term care services and family protection against the cost of the services are very important social goals. This area has been long neglected in the United States but is now beginning to receive widespread attention. The passage of a Federal long term care plan may well be one of our very next major social advances.

Those of us who have been interested in long term care for some time, Mr. Chairman, are greatly encouraged by your assuming a leadership role in seeking passage of a Federal program. S. 2305, in my judgment, thoughtfully addresses the issue and deserves the most careful consideration. It will serve well, as you have suggested, as a base for discussion as consideration of private long term care insurance and a public program continues.

It seems clear to me, as I believe it does to this Committee, that the problem is of a size and difficulty that calls for a partnership of private and public effort. Voluntary private insurance cannot alone meet the need for most people, and reliance on private insurance as the major instrument of advance protection would mean that Medicaid would continue its dominant role. At the same time, public protection provided without a means test need not do the whole job to be effective. Private insurance can play an important if limited role.

Insurance is surely a better approach than individual saving. Although everyone is exposed to the risk of needing long term care, either at home or in a nursing home, only a minority will actually need expensive care. For example, at age 65 there is a 40 percent risk of being in a nursing home sometime before death, but for most people the stay will be relatively short. Only 10 percent will be in a nursing home for over a year, and yet it is this group which accounts for 90 percent of nursing home expenditures, including the expenditures incurred by this group during the first year. With a distribution of costs like this, it is wasteful for each family to try to save for the worst case. Protection can be achieved by paying a premium equal to the average cost. This is the essence of insurance.

Private insurance having discovered the long term care insurance market in the last few years is producing a large number of new and improved products, and just about every major insurance company is now active in the field. This development is very encouraging, and I believe that private insurance can play a substantial role in meeting the need. It would be a mistake, however, to extrapolate the progress made and assume that private insurance can meet the need alone. We need a partnership between private insurance and a universally available public program with an improved Medicaid means-tested program available for those for whom the universal public program, private insurance and their own income and assets prove inadequate. Such an approach to long term care is similar in concept to the nearly universal provision of cash benefits on retirement by Social Security, supplemented by private and government occupational pensions and underlying the whole the means-tested Supplemental Security Income program.

There are many reasons why private insurance cannot be relied on to do the whole job, but one of the most important is the cost to the individual. The cost of an adequate policy when measured against the other needs to be met out of the wages of middle- and lower-income workers is necessarily high and there is no way through private insurance to temper the costs for those with below average incomes. Policies paid for by the individual, as distinct from the employer-paid-for acute health care group policies now in existence, necessarily charge premiums as closely related to individual risk as possible in order to avoid a competitor taking away the business of those whose premiums are too high when measured against the individual's personal risk. This means that there is no way to cross-subsidize, as in employer-paid-for group insurance of all kinds, and that the full cost of the flat premium charged falls on each family alike regardless of their ability to pay.

A flat payment, the same for all, is, of course, much harder for middle-income and lower-income people to pay than for higher-income people. It is the most regressive form of payment, and is in sharp contrast to financing through government, which, for example, in the case of hospital insurance charges the $40,000 a year worker four times as much for the same protection as the $10,000 a year worker. Consequently without employer help with financing (and I know of no one who seriously expects employers to take on this added health insurance cost), large numbers of people will not be able to afford private insurance. Moreover, large numbers with relatively low assets will find little reason to buy the policies even if they could just manage the payments.

A second major limitation of private insurance is that there is no good way to provide protection against inflation at a cost people would be willing to pay. The flat premiums of private insurance will have to be regularly increased to cover future inflation unless the purchasing power of the benefits are allowed to greatly deteriorate. On the other hand, government financing, say the income tax or the payroll tax, rises automatically with inflation. There are, of course, other well known problems facing insurance companies when they sell protection individual by individual. For example, to avoid adverse selection they must set up underwriting rules that are necessary from a business standpoint but prevent some people from getting the coverage they need. Even using extraordinarily optimistic assumptions about the purchase of private insurance--essentially that all those who could pay the premiums with five percent or less of their incomes would actually buy policies--the conclusion of the recently issued Brookings Institution study was that by the year 2016 private insurance would be paying between 7 and 18 percent of nursing home costs.

But let me balance these limitations of private insurance when viewed as a total solution by emphasizing my belief that private insurance can work as a supplement to a public program for those who are relatively well off and have significant assets to protect.

What then does this add up to? What should be the roles of private insurance, a universal public program, and the means-tested Federal/state Medicaid program? S. 2305 proposes one arrangement: a social insurance program protecting against the cost of home care and respite care and a nursing home provision with a 30 percent copayment and a two-year waiting period during which private insurance would be encouraged to sell protection to fill the gap. Medicaid would continue for those who did not buy private insurance covering the first two years and did not have enough in the way of income and assets to pay their own way and would also continue to fill in copayments for low-income people.

I have an alternative arrangement of the public/private partnership that I would like to suggest for your consideration. I believe it has some advantages. I would propose the same sort of coverage for home care--that is, a comprehensive home health and respite care benefit available after only a short waiting period, say a month, and with a small, perhaps 15 percent, copayment lasting as long as needed. The difference arises on the nursing home benefit. For the same cost, or perhaps somewhat less, it would be possible to provide a nursing home benefit covering the first six months of a nursing home stay for everyone with a 15 percent copayment plus an extended benefit with a 30 percent copayment for those who had a spouse living in a private or semi-private arrangement (i.e. a private residence, a room and board home, or a retirement home). Those not fully covered by such a plan would be almost entirely those who could be expected to stay in a nursing home for the rest of their lives and, by definition, who had no spouse in the community. The insurance needs of those in this group with assets would be the protection of those assets for their heirs, primarily sons and daughters. Although important, this objective seems less a public purpose than a private one and thus ideally suited for private insurance. Those who fail to buy private insurance and those who have little in the way of assets to protect and who therefore would not be interested in private insurance would have their costs met by Medicaid following the six months paid for by the Federal plan (or extended coverage in the case of those with a spouse in the community). Income above a personal allowance of, say, $100 and assets above a protected amount of, say, $5,000 would first be used to pay for nursing home care before Medicaid paid the rest of the bill.

There would, of course, be substantial savings to Medicaid in covering the first six months of nursing home care and in the extended benefit for those with spouses in the community. I would propose that part of those savings be used to liberalize the Medicaid nursing home provisions as just described and to insure an upgrading in the quality of care. Medicaid would also continue to fill in copayments for low-income people unable to afford the payments. The remaining Medicaid savings would be retained, not for the financing of the long term care program, but rather to extend the coverage and improve the quality of services provided by Medicaid to groups other than the elderly, particularly children.

At one time, Mr. Chairman, I favored a more comprehensive, non-means-tested Federal program to meet the long term care problem, but in view of the many other pressing needs for new and expanded government programs, and in view of the continuing deficit, it now seems to me important to design a universal plan for long term care that meets only the highest priority public policy purposes and leaves a major part of estate protection to private insurance.

In thinking about this I came to the conclusion that the most important public purpose long term care needs are (1) providing help to family members who have taken on the responsibility of caring for seriously disabled people at home; (2) protecting the income and assets of nursing home patients when they return to private or semi-private living arrangements and thus have a continuing personal need for their income and assets; and, (3) the protection of the family income and assets for the use of spouses of nursing home patients. Of overriding importance is the provision of quality care to the impaired person, whether at home or in a nursing home, and whether for a short or long period, care designed to support the highest possible level of independent functioning. Any Federal plan must provide for the upgrading of services, an emphasis on the restorative and preservation of independent functioning at the highest level possible and choice for the family in determining the setting and services needed. The Federal plan must also contain adequate dedicated financing and a strategy for cost control. This is true for all plans.

The plan I am offering for your consideration is based on the thesis that those who stay in nursing homes more than six months, are not married, and are severly disabled seldom return to living in the community, and, therefore, that the six months benefit plus an extended benefit as long as a spouse is living in a private or semi-private residence would be sufficient when combined with home health care and respite care to meet the highest public priorities as I defined them earlier.

To test whether the limited nursing home benefit fulfills these highest priority needs, let us look at some unpublished discharge data from the 1985 National Nursing Home Survey. In the twelve months prior to the survey, there were 877,000 live discharges. Of these, 284,900 patients had been in the nursing home for more than six months. Of this group, 35,700 were discharged to private or semi-private residences and the rest to another health facility (188,100 to a general hospital, 32,900 to another nursing home). Following through on those discharged to a private or semi-private residence, 25,900 were not married and under the proposal would have lost their eligibility for social insurance protection, but it appears that only 10,600 of this latter group would have met the kind of severe disability eligibility standards contemplated by the plan--that is, inability to perform alone three of the activities of daily living ,ADLs, (such as moving from place to place, eating, dressing, toileting) or the equivalent in disability from a combination of several ADL limitations or who need constant supervision because of a mental condition. For the survey data, it is necessary to use a proxy for this level of disability: those who were either incontinent or needed help with mobility but that would seem to be a reasonable enough proxy for this broad purpose.

In all probability, few of those discharged to another nursing home, general hospital or other health facility after a six months stay in a nursing home, are unmarried, and with the degree of disability indicated would ever return to a private or semi-private residence. They will either die in the hospital or go back to a nursing home. Thus of the 870,000 live discharges, the six month plan and the extension for those with spouses would have failed to protect only a little over one percent from the priority risks of either having their income and assets used when they were needed by a spouse or having their income and assets used and then themselves being discharged to a private or semi-private residence. Left out of the Federal plan after six months would be almost entirely those long stay cases who do not have a spouse and who are not going back to a private or semi-private residence. In the light of other priorities, it may well be reasonable in the case of this group to use any income above a $100 personal allowance and assets above a $5,000 exemption to pay for the cost of any nursing home care not covered by private insurance, with a liberalized Medicaid program paying the residual costs.

The alternative of private insurance for the protection of those with significant assets should be encouraged and could be built on top of the Federal program. The appeal of private insurance would be to individuals in their 60s and 70s and their heirs who want to protect the older person's assets and who would know that the government plan did not provide protection against the cost of nursing home stays of more than six months when only one spouse survived.

The role of private insurance would be important for those with assets, but not crucial for public policy purposes. Under the proposal, the absence of effective private insurance would be the loss of assets to an heir, but the frail elderly and disabled and their spouses would be protected. No one would have to "spend down" or meet any kind of means test before being admitted to a nursing home, although income and assets would contribute to the cost for the nursing home in the case of long stays if there were no spouse in the community and no private insurance protection.

Public insurance with a long waiting period, such as a year or two, on the contrary, depends crucially on the ability of private insurance to fill in the one or two year gap. Without private insurance, most people would have to turn to Medicaid before the expiration of the one to two year waiting period. They would become eligible for a Federal benefit only after they had already used up all or part of their assets and their spouses had typically been forced to greatly reduce their standards of living. For a very large number of people, the Federal program would come too late.

In closing, let me stress that protection against the costs of long term care is a family benefit, not solely or perhaps even primarily a benefit for older and disabled people. It is the middle-aged sons and daughters and their children who are most at risk. They are the ones left to struggle, frequently more or less alone, with caring for disabled parents at home with consequent disruption of the careers of a two-earner couple and the loss of time and money for children. They are the ones usually who must help pay for nursing home care. And the heavy burden falls on a minority who now experience high long term care costs. We need plans that spread the risk to all and thus make the cost bearable.

I have attached an outline of the sort of plan I have proposed, together with suggestions for possible financing.

OUTLINE OF A FEDERAL PROGRAM FOR LONG TERM CARE

Benefits

I. Home Health Care

Home health care would be available for all eligibles after a one-month waiting period following application and would be available indefinitely. The cost of an annual plan for each individual would be limited to 65 percent of the average cost of skilled nursing homes in the area. Persons unable to perform two or more of the activities of daily living (or the equivalent in disability from a combination of several ADL limitations) or who need constant supervision because of a mental condition would be eligible. There would be a copayment of 15 percent of the cost of services.

The annual cost of the benefit for the first full year after the benefit was fully implemented is estimated to be:

$7 Billion

II. A Respite Care Benefit

For the usual caregivers of those eligible for a home health benefit, a respite care benefit would be available for charges up to $3,000 annually, with a 30 percent copayment. The benefit would provide full time in-home care or day care (even though the regular approved plan for home care did not). Short-term nursing home care would also be available for the purpose of relieving the family members who are primary caregivers.

The annual cost for the first full year is estimated to be:

$1.5 Billion

III. Nursing Home Care

A nursing home benefit would be provided for six months for all eligibles unable to perform three or more ADLs (or the equivalent in disability from a combination of several ADL limitations) or who need constant supervision because of a medical condition and whose circumstances make nursing home care preferable to home care.

There would be a copayment of 15 percent of the cost of services and a one month waiting period for those admitted directly to the nursing home rather than after a three day stay in a hospital.

A patient would be eligible for a second six months of nursing home care only after a period of 60 days in a private or semi-private residence (i.e. not a hospital, nursing home, or other medical facility.)

The annual cost of the benefit for the first year once the program is fully in effect is estimated to be:

$9 Billion

III. Extended Nursing Home Care

An extended benefit with a 30 percent copayment would be provided beyond the six months as long as there was a spouse living in a private or semi-private residence (i.e. board and room homes or retirement homes). For this purpose, a spouse would be defined as one who had entered into a marriage with the eligible patient at least two years prior to the time the patient meets the disability standards for benefit eligibility.

The annual cost for the first full year is estimated to be:

	$1 Billion
TOTAL	**$18.5 Billion**

Financing

I. An estate and gift surtax of 10 percent could be imposed on the transfer of assets by gift or inheritance in excess of ($200,000) and earmarked for long term care insurance.

Income the first full year: **$5 Billion**

II. An increase of 0.3 percentage points in the Social Security and Medicare tax on both employee and employer could be dedicated to long term care insurance.

Income for the first full year:	$14 Billion
TOTAL	$19 Billion

There are many alternatives. A $5.00 a month premium paid by the elderly would raise $1.8 billion in the first full year; the hospital insurance tax of 1.45 percent applied to earnings above the Social Security limit ($45,000 in 1988) and earmarked for long term care insurance would raise $7 billion in the first full year; there could be a dedicated surtax on the income tax; taxes on alcohol and tobacco could be increased and the income dedicated to long term care; Medicare could be extended to the 30 percent of state and local employees not now covered with the savings to Medicare (about $2 billion) dedicated to long term care; Social Security benefits could be taxed in a manner similar to the taxation of contributory private pensions and government career plans with the income dedicated to long term care insurance; the taxation of capital gains at death could be dedicated to long term care insurance, and there are, of course, other possible sources of revenue.

Relationship to the Medicaid Program

The financing proposed for the universal Federal long term care plan does not depend on retaining the savings to Medicaid. These savings might amount to about a fifth of what Medicaid would otherwise spend on long term care.

A maintenance of effort provision would require the states (with Federal matching) to liberalize the Medicaid program for elderly and disabled people by requiring the states (1) to increase the personal allowance for those in nursing homes from $30 a month to $100 a month and to increase the asset retention cash allowance from $2,000 (in 1989 for an individual) to $5,000 before patient income and assets could be used for the payment of nursing home costs, and (2) to upgrade Medicaid nursing home standards to assure quality care for federally reimbursed services. The rest of the savings to Medicaid would be used to improve the benefits and coverage of Medicaid for other groups, particularly children.

PREPARED STATEMENT OF RUTH VON BEHREN

Senator Mitchell, Honorable Committee members. I am Ruth Von Behren, Chair of the National Institute on Adult Daycare (NIAD), a membership unit of The National Council on the Aging, Inc. (NCOA).

The National Council on the Aging, Inc., founded in 1950, is a national nonprofit organization. Its membership includes individuals, voluntary agencies and associations, business organizations and labor unions united by a commitment to the principle that the nation's older people are entitled to lives of dignity, security, physical, mental and social well-being, and to full participation in society.

The National Institute on Adult Daycare is the only national organization composed of professionals in the field working to develop and expand adult day care, to advocate for those who rely on adult day care for daily and continuing support and care, and for those working to ensure that adult day care is of the highest quality, based on professional standards of excellence and available throughout the nation.

Thank you for giving us the opportunity to comment on the provisions of S. 2305, the Long-Term Care Assistance Act of 1988.

Last week I toured Western Kansas meeting with various groups of elderly service providers and advocates to identify problems in obtaining health care and long-term care services in rural areas. Over and over I heard, "We can't afford the services, even if they were available." For the poor there is Medicaid; for the rich -- whatever money can buy; for the majority, a lack of quality, affordable health care.

We are grateful that the Congress is seriously addressing the need to adjust Medicare to provide long-term care services, including home care, such community-based services as adult day care, respite and chore services and institutional care. Unfortunately, the lack of a national long-term care policy has created a distorted array of long-term care services under Medicaid, largely biased toward institutional care. Your bill, Mr. Chairman, will go a long way toward realigning Medicare services to fit the altered needs profile of Medicare beneficiaries.

Senate Bill 2305, the "Long-Term Care Assistance Act of 1988," provides a comprehensive framework for addressing these needs. For the first time, albeit after an extended exempt period, chronic nursing home care will become a Medicare benefit, as will chronic home health care. Your bill addresses the need for a respite benefit far beyond the limited range included in the pending catastrophic Medicare Conference Report. It will provide for Medicaid buy-in to protect the interests of poor Medicare beneficiaries. Each of these components, if enacted, will comprise important components of an emerging national long-term care policy.

At the same time, we believe that aspects of S. 2305 require additional review by this Committee toward changes which NIAD considers essential to sound long-term care legislation.

We believe that S. 2305 does not appropriately portray adult day care as the professional, skilled health system that daily is serving thousands of Americans requiring long-term care services.

We believe that the bill errs in slotting adult day care solely as a respite service for caregivers, with severe dollar limitations and co-payment requirements contained in the section on Home or Community-Based Respite Care. Instead, we urge your consideration of shifting adult day care services to complement chronic home care as a direct beneficiary service with important, but secondary, respite consequences for caregivers.

We believe that such a change will not fundamentally alter either the fiscal impact of this legislation or the core intent to array sufficient community-based services to allow impaired adults to remain in their own homes. In fact, we believe that our recommendations will greatly expand care options for beneficiaries, families, attending physicians and case management agencies on a cost-effective basis. We also assert that the services rendered under an adult day plan of care will meet the same standards which this legislation will require of services provided at home.

Finally, we suggest that there is pending Medicare legislation which could provide to this Committee models for incorporating adult day care as a long-term care service option. In short, we believe that our recommendation will not impede, in any way, the progress of this bill toward passage within this Session.

Adult day care is a structured day program provided in a safe environment where functionally impaired adults can receive the social, health and supportive services needed to restore or maintain optimal functioning. Hallmarks are an individualized, comprehensive assessment and a plan of care, involving multidisciplinary staff. Attendance is planned and regular. The primary target population is the impaired adult. The intent is to forestall inappropriate or premature long-term institutionalization and to return the beneficiary in an improved condition to his or her own home.

Services provided at the typical adult day care center include nursing, personal care, social services, physical and occupational therapies, nutritional counseling, transportation from home to center, noon meal, family counseling and support and therapeutic recreation. Medical supervision is usually provided by either the participant's private physician or a consultant staff physician. Additional consultant services include speech therapy, podiatry, psychiatry and dentistry. These services, provided on a cost effective, group basis, meet, at minimum, professional and quality assurance standards required of home health care agencies under Medicare and Medicaid.

Mr. Chairman, adult day care is not a new, arcane or remote service unknown to the states. In fact, 41 states now apply standards for licensure, certification or funding of adult day care. Such services to adults under Medicaid, the Older Americans Act, state long-term care resources and through private payments and co-payments are provided in all 50 states.

NIAD will provide to this Committee extensive documentation, including numerous state and privately sponsored evaluations, demonstrating the availability of these services across the nation under requirements meeting federal standards.

Adult Day Care Services

For the Participant:

Adult day care restores or maintains optimal functioning of impaired adults. Every center can provide information about small miracles that occur, for example, a person formerly in a wheelchair now walks. A state of California evaluation study in 1982 found that 87-96% of adult day care participants maintained or improved functioning.

For the Caregiver:

Business surveys are identifying, in increasing numbers, the impact of caregiving on their employees. Adult day care is recognized as a valuable asset, as it provides respite to the caregiver and relieves stress, enabling the caregiver to continue providing care and helps employee productivity.

For the Government:

By utilizing the benefits of a group setting, adult day care costs less than the one-to-one provision of home health care. On a monthly basis it costs less than a nursing home. Reports from states such as California, Hawaii, New Jersey and Massachusetts indicate state satisfaction with adult day care's costs and effectiveness.

On Lok Senior Health Services, my agency, has found the use of Adult Day Health Care (ADHC) a vital component in the reduction of hospital utilization. On Lok, a capitated, at risk comprehensive long-term care system, funded by Medicare and Medicaid, sees the ADHC center as the focal service delivery site. The monitoring and supervision of health status at the ADHC center enables On Lok to prevent small health problems from becoming major problems needing hospitalization. The hospitalization rate for our elderly persons certified for nursing home care is .7% of enrollment days, less than one third the average rate for this population, and even lower than that for a general 65+ population (1.1%). In our current replication program, authorized by Congress in 1986, all prospective On Lok model sites must develop ADHC if it is not already in place.

Based on this extensive experience of meeting the long-term care needs of hundreds of thousands of impaired adults, we recommend two major changes in S. 2305:

- delete adult day care as a respite service under the Home or Community Based Respite Care section;
- incorporate, under Title I of the bill, provisions to add adult day care as a specific benefit and as a companion service to chronic home care services.

We suggest that S. 1839, introduced this Session by Senators Melcher, Bradley and Heinz, can provide to this Committee the elements necessary to define adult day care as a Medicare benefit under S. 2305. Incidentally, S. 1839 is now co-sponsored by 15 Senators, including your colleagues on this Finance Committee, Senators Durenberger, Moynihan, Matsunaga and Chaffee.

S. 1839 establishes adult day health care as a distinct Medicare service with service and eligibility requirements, certification standards developed by DHHS with consultation from NIAD, eligibility determination by state pre-admission or Medicaid long-term care agencies, and surveys by the appropriate state agency. While S. 1839 limits adult day care reimbursement to 100 days annually, we would suggest that it be reimbursed on the same basis as chronic home care.

Recent further analysis of the NIAD 1985-86 National Survey indicates that many centers will have no difficulty in meeting the service requirements of S. 1839.

Particularly noteworthy is the fact that all centers, regardless of licensing or funding source, do provide at least two of the following professional services: nursing, social services, physical therapy and occupational therapy. Even more significant is the provision by 40% of our centers of one or more of the following medical services: physician assessment and treatment, psychiatry, podiatry and dentistry. These figures represent only services provided by staff or contract, and do not include the informal alliance with participants' private physicians, which is a part of every adult day care program.

Medicare reimbursement, as outlined under S. 1839, would increase center resources, thus enabling those centers that wish to qualify for certification to add additional services if needed.

Medicare funding through S. 2305 is needed for the following additional reasons:

1. Medicare coverage for adult day health care will make the service accessible to those low- and middle-income persons who do not meet the income eligibility requirements for Medicaid or the Social Services Block Grant program, but cannot afford to pay for these services.
2. Medicare is a trend-setter for private health insurance coverage. Medicare coverage will point the way towards inclusion of ADHC in supplemental long-term policies.

The private sector is just beginning to offer coverage for adult day care in insurance policies. Three companies, Travelers, Aetna and Prudential (for AARP), already include adult day care as a benefit for either group or individual coverage. Others will follow if Medicare leads the way.

NCOA/NIAD acknowledges the leadership of these companies. However, insurance policies are long-term. Persons who need ADHC now will not be accepted by any long-term care policy. Insurance policies will reject persons currently eligible. Also, premiums for persons of advanced age are higher, making the policies unaffordable. Therefore, although such policies should be strongly encouraged, the needs of our current long-term care population cannot and should not be ignored.

Program Growth

I have worked with ADHC since 1975 and have experience both as state administrative official and provider. The "woodwork" theory has been raised numerous times. I have yet to see it happen. There are several reasons why:

1. Admission to ADHC implies that the participant and the caregiver need help. Neither likes to admit they can't function independently, so they put off admitting this until a crisis is imminent or actually occurs.
2. ADHC is a service-intensive program. The major reason for being in an adult day care center is a service need.
3. Eligibility controls and case management standards will ensure that only persons who need the services will receive them. NCOA/NIAD feels there are adequate controls.

The "woodwork" theory has also been applied to providers. There is fear that uncontrolled growth will occur if Medicare reimbursement is available. There are several reasons why extremely rapid growth is not likely:

1. The start-up and development time involved in establishing an ADHC center.
2. Past experience of other providers when Medicare reimbursement began.

ADHC is a complex program involving facility renovation; equipment purchase; licensing and certification application and review; policies and procedures development; staff recruitment, hiring and training; and, marketing and outreach. In California, it takes a minimum of a year and often much longer, to bring an ADHC center from design to operation. If funds for development are lacking, the developmental period may double or triple.

NCOA/NIAD has other concerns relating to S. 2305:

1. Case management is required for eligibility. This requires more specific guidance as to placement and structure.
2. The Eligibility review process to determine an individual's eligibility for these Medicare long-term care benefits allows up to 60 days for the decision. This is far too long for a chronically ill individual who needs services immediately.
3. The two year waiting period for Medicare coverage of chronic nursing home care is far too long. According to the House Aging Committee, nearly 70% of single elderly persons would be financially impoverished after just 13 weeks in a nursing home; within a year, 94%. For 34% of couples, impoverishment occurs after one spouse has spent six months in a nursing home; for 78% at the end of a year.

4. The $500 deductible for chronic home health care and the 50% match for respite care will result in many persons not able to use the services because they can't afford the deductibles. I am especially concerned with low income persons who have not qualified for Medicaid.
5. NCOA/NIAD would also like to suggest that the definition of "institutionalized spouse" in §1923, Treatment of Income and Resources for Certain Institutionalized Spouses, be expanded to include spouses of persons receiving chronic home care and/or adult day care, as specified in Title III, §301, 31(B)ii, your definition for "qualified facility."

Mandating such provisions only for institutionalized spouses once again gives an incentive to place the spouse in an ICF or SNF. Equal treatment is needed for spouses who seek to prevent institutionalization by using adult day care and/or home care.

A recent poll of 2001 Americans over the age of 45 commissioned by the American Association of Retired Persons and conducted by Hamilton, Frederick and Schneiders found that a federally administered long-term care program similar to Medicare or Social Security is preferred by 84% of the respondents. Respondents are also willing to pay for it with a $20 to $58 per month increase in Social Security tax (depending on income) to cover the costs.

Senators, the need is there; the time is right. NCOA/NIAD commends you for addressing these long-term care issues.

NCOA/NIAD asks that you develop a Medicare funded comprehensive long-term care system which includes in-home, community-based services, including adult day care and institutionalization.

We ask that barriers of high deductibles be removed and this system be accessible and affordable to those needing its services.

Thank you for giving me the opportunity to present NCOA/NIAD views on this important legislation.

STATEMENT
ON
LONG-TERM HEALTH CARE
before the
SUBCOMMITTEE ON HEALTH
of the
SENATE COMMITTEE ON FINANCE
for the
U.S. Chamber of Commerce
by
Daniel P. Bourque
June 17, 1988

Mr. Chairman and members of the Subcommittee, my name is Daniel P. Bourque. I am Senior Vice President for the Voluntary Hospitals of America, the nation's largest alliance of nonprofit hospitals. I am also a member of the U.S. Chamber of Commerce's Health Care Council and I served as the Chairman of the Task Force on Long-Term Health Care Policies of the Department of Health and Human Services (HHS), appointed by Secretary Otis R. Bowen, M.D. I am pleased to appear today on behalf of the Chamber. I am accompanied today by Frederick J. Krebs, Director of the Chamber's Employee Relations Policy Center.

Mr. Chairman, the Chamber applauds you for beginning this important dialogue on long-term care in a sincere effort to find a workable and affordable solution. Finding the best solution will require input from as many sources as possible. The Chamber appreciates the opportunity to present its views on this important topic.

I would like to focus my remarks on the Chamber's perspectives on the ways to address the need for long-term care coverage, on the recommendations of HHS's Task Force on Long-Term Care Policies, and on S. 2305.

The Need for Long-Term Health Care

The need for Congress to address the issue of long-term care is indisputable. Many elderly Americans and their families already face impoverishment as they strive to meet the costs associated with nursing home or extensive home health care services. Frequently, middle-income elderly find themselves "spending down" to eligibility for Medicaid -- a program designed for the nation's poor. The average nursing home stay costs $22,000 annually -- a large burden for almost any family to bear if they lack some form of private or public insurance coverage.

The realities of the demographics of our population ensure that this problem will only grow in the future. Today there are 2.2 million Americans over age 85 and approximately one-fifth of them reside in nursing homes. By the year 2000 — only twelve years from now — the population over age 85 will more than double to 5.5 million, and we can expect a commensurate increase in nursing home residents. HHS estimates that the lifetime risk of entering a nursing home is now between 20 and 45 percent. And for the elderly who spend more than $2,000 of their own money annually on health care, 80 percent goes to nursing home care. Obviously, the need to find affordable ways to pay for this coverage is paramount and urgent.

The high cost of such care and the demographics of an aging population make "pay-as-you-go" financing far less desirable than prefunding for long-term care needs. Few individuals are able to finance an extended nursing home stay or other long-term care service entirely out of their assets and income. Given the current federal deficit picture, the same could be said for government's ability to finance a new long-term care program.

Business has been the focal point in addressing various health policy issues. Indeed, employers do have an important role to play in this and other health care policy debates. But with many competing interests vying for limited financial resources, we must set priorities. We must sort through all possible options and devise a plan that takes into account all of the needs and resources -- both public and private -- available to us.

Fortunately, despite the enormity of the national challenge to provide long-term care, there are positive steps that can be taken to help the elderly, today and tommorrow, meet their long-term health care needs.

General Principles

To deal effectively with the issue of long-term care, we should all recognize some important points. First, there is no single way to solve this problem. Its solution will require multiple strategies and demand the best in innovation and resources from both the private and public sectors.

Mr. Chairman, you are to be commended for developing a response to this need that combines private and public approaches. Health care coverage in this country is, and rightly should be, a private and public sector partnership.

For those individuals whose modest means prevent them from securing private long-term care insurance, a firm commitment to a variety of public financing programs is necessary. But the Chamber believes that, to the extent possible, the private sector market for long-term care -- like health care coverage generally -- should be encouraged. Public policies should encourage and help make possible the purchase of long-term care coverage for those who can afford it. Mr. Chairman, in recognition of the important role private coverage must have in addressing the nation's long-term care needs, your bill provides incentive to encourage the expansion of this market.

Second, addressing the questions of financing alone will not satisfy our long-term care needs as a nation. The complexity and magnitude of the problem will require new and expanded delivery systems, effective methods to contain costs, and research breakthroughs to reduce disability and improve the quality of life for those in need of long-term care.

Third, public policies aimed at addressing the need for long-term care should not discourage the extensive network of informal care that is currently provided by family members and friends. In fact, policies should support and encourage such informal care. Again, Mr. Chairman, your bill's provision for respite care recognizes and reinforces this important role.

Fourth, education of the public on the importance of seeking protection from long-term financial catastrophe is vital. Too many people simply do not understand what Medicare does and does not cover. We cannot expect consumers to make informed choices without sufficient information on the types of coverage they are entitled to already. There is strong evidence that with education, younger people can be encouraged to protect themselves from future long-term care expenses.

The HHS Long-Term Health Care Policies Task Force that I chaired issued a report to Secretary Bowen in September of 1987. The report contained 41 recommendations for meeting the challenge of long-term health care. The Chamber supports a number of the Task Force's recommendations, the most important of which I will discuss today.

The Private Market for Long-Term Care Insurance

I cannot stress enough the vital role that private long-term care insurance potentially can play in meeting the financial concerns of the elderly. Because of the efficiencies of pooling risks and the internal buildup of accumulated reserves, insurance provides an efficient means of meeting financial risks that are too great a burden to bear alone.

In the past three years alone, there has been a dramatic growth in the private insurance market for long-term care policies. The number of insurance companies offering such coverage has grown from about 20 in 1983 to more than 80 today. And the number of individuals covered by these policies has increased from 100,000 to nearly half a million.

During this time, we also have witnessed a substantial change in the types of policies being marketed and sold. For example, policies now include features such as inflation adjustors, case management, alternative home and community-based services, and eligibility criteria based on the limitations of the insured person's ability to fulfill certain daily living activities. In addition, exclusions for specific conditions such as Alzheimer's disease and prior institutional stay requirements are being removed. Increasingly, the typical idemnity benefit policy with a permanent fixed daily dollar limit for institutional or nursing home care is being augmented with products more responsive to consumer's desires and needs.

Another important and recent development is in the area of employer-sponsored long-term care insurance. A year ago, virtually no employer plans were available. Today, more than half a dozen large employers offer this coverage to their employees -- including American Express, Proctor and Gamble, the states of Alaska and Maryland, Aetna, and John Hancock -- and the list is growing. A survey by the Washington Business Group on Health found that more than half of the companies surveyed had investigated or were planning to investigate within the next two years the possibility of offering a long-term care benefit to employees and/or retirees.

The early experiences of these employer plans have been encouraging. Enrollment rates have reached nearly 15 percent, even when the employee is asked to pay the entire premium. The average age of purchasers has ranged from the low 30s to the low 40s and the percentage electing spousal coverage has been high. Some plans even allow employees to purchase coverage for their parents.

The HHS Task Force underscored the importance of the employer-sponsored market as the most effective way to expand rapidly the availability of long-term care insurance. Offering this insurance through employment is an effective means of making it readily available, attractive, and affordable to large groups. Not surprisingly, it becomes even more attractive if the appropriate tax incentives are available.

The public and private sectors should take immediate steps to encourage the expansion of long-term care protection. The current heightened awareness of the need for financial protection against the potentially ruinous costs of these services makes this an ideal time for stimulating growth in long-term care coverage. The market will need time to develop, and the sooner we begin, the better.

Encouraging the Development of the Private Long-Term Care Market

Federal policies could significantly enhance the growth and breadth of the employer-sponsored long-term market. The HHS Task Force recommended the use of tax incentives to encourage the purchase of long-term care insurance. Obviously, we all must be sensitive to the potential lost revenues resulting from tax incentives. However, a range of tax policy options exist that would assist the private market in some way, each with a different federal revenue impact.

Mr. Chairman, your proposal incorporates several important tax incentives for long-term care insurance. S. 2305:

- o Clarifies the tax treatment of long-term care insurance reserves and the investment earnings credited to them.
- o Gives long-term insurance the same tax status as health and accident insurance.
- o Clarifies the tax treatment of long-term care insurance to employers offering group coverage and to employees receiving long-term care benefits.
- o Provides that long-term care expenditures and insurance premium payments are deductible medical care expenditures.

The two-year exclusionary period for nursing home care provided for in S. 2305 would help to stimulate demand for long-term care insurance to cover the exclusionary period for the benefit, the copayment requirements, and other long-term care costs not addressed in the bill.

Other options are also possible. For example, long-term care insurance plans could be linked with other insurance programs and with pre-paid health plans -- such as Health Maintenance Organizations and Continuing Care Retirement Centers. One proposal suggested by the Task Force would permit employees the option of directing a portion of their vested pension benefits, including Keogh plans, Individual Retirement Accounts, and 401(k) plans to the purchase of long-term care insurance. These tax incentives would encourage individuals to take financial responsibility for their future needs.

The commensurate savings in the Medicaid program over time may more than offset the tax expenditures needed to stimulate the private insurance market. In 1986, outlays for nursing home care amounted to more than $38 billion -- and more than $15 billion of these costs were Medicaid expenses. These public expenditures would be reduced signifcantly as the private system prospered. The HHS Task Force, using a Brookings Institution model, projected that by the year 2020 $1 of tax benefit for stimulating long-term care insurance would yield $2 of savings in Medicaid spending to the federal government.

The long-term health care dilemma is complex and assuredly will be expensive to solve adequately. The Chamber, however, has reservations about a major expansion of Medicare at this time. Long-term care is one complex facet of the broader and even more complex health policy picture, which includes the needs of the uninsured and underinsured. We must determine how to best allocate our limited resources among competing interests. The Chamber is currently establishing a panel to examine these important issues and make policy recommendations on how to meet U.S. health care needs.

Conclusion

Mr. Chairman, in introducing S. 2305 and conducting these hearings, you have provided an excellent starting point for this debate. The Chamber applauds you and the other members of this Committee for drawing needed attention to this problem. We pledge the Chamber's assistance in your search for workable and affordable methods to meet the nation's need for long-term health care protection.

Statement
# of the
Health Insurance Association of America
On
S. 2305, THE LONG TERM CARE
ASSISTANCE ACT OF 1988

Presented by
Bruce L. Boyd
Vice President, Teachers Insurance and Annuity Association/
College Retirement Equities Fund

Good morning Mr. Chairman and Members of the Subcommittee. I am Bruce L. Boyd, Vice President, of the Teachers Insurance and Annuity Association and College Retirement Equities Fund. I am manager of the Group Insurance Operations Division which provides over 2,000 group disability, life, and medical plans to colleges, universities and other educational institutions for their employees, and insures over 500,000 people.

I am pleased to testify today as Chairman of the Long Term Care Task Force of the Health Insurance Association of America. The HIAA represents some 350 insurance companies which write over 85 percent of all commercial health insurance in this country.

HIAA applauds Senator Mitchell's interest and that of the Subcommittee, in addressing the important national problem of long term care and his recognition that the private sector should play a role in paying the nation's long term care bill. We also understand that S. 2305 has been introduced as a vehicle to begin a national discussion on financing long term care and that many views will be considered in shaping the ultimate structure of the bill. In the Chairman's own words, the bill "is not a panacea" but "rather, a sincere effort to reform the way long term care services are delivered and paid for." HIAA welcomes the opportunity to work with the Chairman and his staff as the provisions of S. 2305 are refined.

The insurance industry is justifiably proud of the role it has played in the evolution of the largest private insurance system in the world. The overwhelming majority of adult Americans now have private life and health insurance and the great majority of the "ERISA workforce" participates in pension plans.

This situation didn't occur overnight. It evolved, mainly after World War II, as the nation's growth and productivity increased national income and allowed people to look beyond cash income to securing themselves against premature death, unexpected illness or disability, and planning for retirement.

Now, we are entering the next logical phase of this evolution. The advances in both medical technology and general health that are increasing the lifespan of the elderly are also increasing the number of people who may require treatment for chronic illness. Simultaneously, rising income, particularly among the elderly, makes insurance against the costs of long term care both desirable and affordable. The time has come to begin folding long term care into this country's extensive private insurance system.

Our testimony will focus on four areas:

- the nature of the long term care problem and why it lends itself to insurance coverage;
- the new developments in long term care insurance products;
- the challenges we face in attempting to meet the need for long term care insurance; and
- the specific provisions of S. 2305.

Nature of the Problem

When we speak of "long term care," we are describing a wide range of medical and support services provided to individuals who have lost some or all capacity to function on their own due to a chronic illness or condition and who are expected to require these services for an extended period of time. About

70 percent of the noninstitutionalized elderly with long term care needs receive their help solely from family members and friends. However, others need paid home care services and nursing home care.

Long term care is the major catastrophic health care expense faced by the elderly today. On average, for those elderly with out-of-pocket health care expenses over $2,000 a year, 80 percent goes toward nursing home care. With nursing home costs estimated to average $22,000 - 25,000 per year, such expenses can indeed cause financial ruin.

Over the last three decades, both the public and private sectors have focused their attention on the enormous tasks of improving the scope of coverage for acute health care and the financing of pension plans. The public and private sectors are just beginning to focus on the need to establish a systematic program of insuring long term care costs. Currently, nearly half of all nursing home costs is paid for by Medicaid and the other half is financed out-of-pocket on a pay-as-you-go basis. There has been very little prefunding of private resources to minimize this financial drain. As a result, middle income people are forced to impoverish themselves, "spending down" almost all of their resources and becoming eligible for Medicaid -- a health care program intended for the poor. This all-or-none financing approach also encourages some people to divest themselves of assets in order to qualify for Medicaid benefits.

Not everyone will need paid long term care services. For example, it is likely that somewhere between 60 and 75 percent of the elderly will not enter a nursing home. Of those that do, about half will be institutionalized for more than 90 days. Therefore, long term care embodies many of the characteristics of a situation suited to insurance: a potentially very expensive event, difficult to predict for a given individual, and for which the frequency is sufficiently low that the cost per person, spread across a large group, can be relatively modest.

Private insurance, however, cannot provide the answer for everyone. Insurance products are not designed for nor do they lend themselves as financing vehicles for some segments of the population such as those with low incomes. Providing care for this population should be the objective of public programs and reforms are needed to improve the government's ability to act as a responsible safety net for those who must rely on it.

HIAA supports the Medicaid reform provisions in S. 2305. We believe that the Medicaid program must be enhanced for those individuals who are unable through insurance or their own resources to provide for the cost of their care. These incremental Medicaid changes are necessary regardless of whether or when a final financing solution is developed and are clearly critical ingredients for a comprehensive bill such as S. 2305.

New Developments in Long Term Care Insurance

There has been a small private market for long term care insurance in this country for some time. However, widespread consumer misunderstanding about the extent of Medicare coverage, coupled with other, higher priority uses for their funds were two of the primary reasons why spending for private long term care insurance has had little appeal.

Recently, that has changed dramatically, as evidenced by the number of companies developing long term care insurance products, the number of individuals covered and the variety of products being developed. There are now about 80 companies selling a long term care product and almost all of this growth is since 1985. Today, there are about one-half million policyholders. Some companies report doubling their number of policies in force each year.

More importantly, the products themselves are changing rapidly. Because of the lack of experience, the early products tended to be more limited. For instance, they covered only stays in a nursing home and then only following a hospital stay. But virtually all of the newer products offer nursing home and home health care, frequently without a prior hospitalization. Instead, benefits are triggered based on functional limitation measures. In addition, some policies are now providing inflation protection against future long term care costs. We will see a continued trend toward more comprehensive and liberal benefit provisions as private sector insurers and the consuming public become more sophisticated.

The recent introduction of employer-sponsored plans is particularly promising. Such plans offer the opportunity to efficiently reach a large number of people during their working years when premiums are more affordable. A year ago when we testified before your Subcommittee, only one employer plan had been introduced. Six months later, at the end of 1987, there were five more. Several employers have expressed interest in offering a plan in 1988.

The enrollment experience to date has shown the average age of the employees electing this coverage is in their early 40's. This is strong evidence that with education, younger people can and will purchase long term care protection. And, most of these plans provide coverage to the elderly including retired employees and parents of the worker and worker's spouse.

The insurance industry is moving rapidly to serve more people and offer a wider range of services. Clearly, the availability of home and community-based care are highly desirable from a social perspective and can also be cost-effective under the appropriate conditions. HIAA is pleased to see that S. 2305 recognizes the importance of noninstitutional long term care services by offering home and respite care benefits.

Challenges to the Long Term Care Insurance Market

There are several factors which have inhibited the development of long term care insurance. In varying degrees, these factors still operate today. The most important of which are:

- A low level of consumer awareness about the risks and costs of long term care, coupled with a widespread belief that Medicare and supplemental Medigap policies cover long term care costs.
- A lack of usable data by insurers regarding the use and costs of long term care services, particularly in an insured environment, which makes actuarially sound pricing of products difficult.
- An uncertain public sector tax and regulatory environment for companies developing long term care insurance.

Consumer Awareness

The need for better consumer education is the responsibility of both the private and public sectors. It should begin early, so that people can purchase insurance when they are younger and premiums are more affordable.

HIAA has undertaken a number of initiatives in this area. I have submitted for the record one example of our efforts, the Consumer Guide to Long Term Care Insurance. HIAA remains willing to work with all levels of government to further these communication and education efforts.

Data Needs

The development of an effective plan design and the appropriate pricing of policies relies on a good body of data. The data that do exist are fragmented and in many areas are lacking. For example, there are almost no data on the rate at which private pay patients exhaust their resources to become Medicaid eligible. And, information on the lifetime use of nursing home care is also limited.

Our knowledge gaps make it very difficult to predict the future costs of a publicly funded long term care program. Furthermore, these uncertainties strongly suggest that the private and public sectors take the several incremental steps necessary to develop the components of a rational long term care system in order to create a sound national policy.

Federal Tax Environment

Long term care insurance is a new product which has an uncertain status under the current federal tax code. In order to stimulate the growth of private insurance, especially employer sponsored coverage, and to reduce the costs of long term care insurance, it is necessary for the federal government to clarify the tax status of long term care insurance and to remove barriers to several logical and effective product designs. HIAA is pleased that S. 2305 recognizes the importance of these concerns and we support the bill's provisions that would address the current obstacles created by these uncertain tax issues.

State Regulatory Environment

Long term care insurance is a new product that continues to evolve. Insurers need a state regulatory environment which is sufficiently flexible to allow for the development of new and different products but is equally effective in protecting consumers. In December 1986, the National Association of Insurance Commissioners (NAIC) adopted model legislation that successfully balances these two objectives. In the last 18 months, 13 states have passed the model bill and another 8 are expected to pass this bill by the end of 1988. HIAA supports this critical legislation and is working actively in those remaining states for its passage.

Specific Provisions of S. 2305

HIAA supports the comprehensive approach taken by S. 2305 and many specific provisions of the bill. However, we believe that it is premature to consider a government entitlement program that is structured to pay benefits based on length of use rather than financial need. After thoughtful analysis and discussion, HIAA has concluded that an approach such as the 2-year exclusionary period proposed in S. 2305, is premature for several reasons. These reasons include:

- A time period is an arbitrary measure of need; it over-assists individuals with resources to pay for care beyond the time period and it is inadequate for persons who cannot manage the cost of the "exclusionary" period in a nursing home. And, the vast majority of private insurance plans provide coverage in excess of 2 years.
- The cost of private insurance is determined more by the age at purchase than the length of time for which it provides benefits. Affordability is enhanced by purchasing at younger ages, accruing funds over an extended period, and spreading risk over a large population.
- There are many uncertainties about long term care including the extent of future long term care use, especially for home and community-based care; the most cost-effective case management methods; the resources available to those who enter nursing homes; and the impact that third party payment could have on all of these issues. We therefore, believe it is preferable to pursue potential public-private partnerships through smaller scale, controlled demonstrations that can be adjusted and modified to provide insight into the design of a successful national program.
- An entitlement program that leaves the insurance industry with only a gap-filling role would certainly limit the progress and experimentation currently underway in the private market. Fitting the gaps of a federal program would require that most features of the products be standardized or virtually identical.
- Given the recent experience with Medigap and catastrophic legislation, insurers are reluctant to devote large resources to a new product line that could greatly diminish over time. Under S. 2305, private insurance benefit structures funded over an extended period could prove inadequate or redundant when needed if government, as often happens, changes the rules of the partnership over time. Not only could this have an adverse affect on consumers, it also will tend to limit the number of companies willing to experiment and fund the development of long term care policies.
- The proposed stop-loss structure could have a negative impact on the fledgling employer group market. Some insurers believe it could discourage insurers and employers from offering any long term care coverage because of the uncertainty of future government programs.

In general, HIAA is more supportive of a government program that would provide needed benefits after individuals have used some designated portion of their own resources to pay for care. In this way, government policy would be focused on helping individuals based on the adequacy of their own resources, rather than a preset time period. Such a policy should also prevent individuals from impoverishing themselves as they currently do under Medicaid.

In addition, HIAA believes that the deductible for the nursing home and home care benefits should be combined to minimize incentives for overusing home care services because of its significantly lower deductible. This deductible period, in total, should be based on an individual's resources rather than a preset time period for nursing home care and a less costly dollar deductible for home care. The home care benefit should also be offered in a way that will minimize the substitution of paid care for the vast amount of care that is currently provided by informal caregivers.

HIAA continues to support state experimentation to develop the most efficient and effective long term care financing and delivery system between the public and private sectors. We believe that the evaluation of these projects will provide valuable knowledge to policymakers. In this regard, HIAA supports federal legislation that would permit these state experiments to take place.

In addition to questions raised about the general structure of the new program proposed by S. 2305, HIAA believes that the linkage between the private insurance plans expected to fill the 2-year exclusionary period and the public long term care program needs further consideration. We welcome the opportunity to sit down with you or your staff to more clearly define and address these issues. Questions about the coordination between the private and public sectors include:

- Why are different eligiblity criteria specified for private insurance plans versus the proposed federal program? How would beneficiaries be affected by these different eligibility requirements across the two different payors?

- Who is responsible, both functionally and financially, for the case management of patient services? Is the private sector responsible under private insurance and the public sector responsible under the proposed federal program? How will the process be made uniform and consistent to serve the beneficiary in the most cost-effective manner?

- Why are different provider eligibility criteria specified for private insurance plans versus the proposed federal program? How would this affect beneficiary access to appropriate care?

Finally, HIAA questions whether this proposal is the best way to spend an initial $18 billion to solve the nation's long term care financing problem. Given Medicare's current commitments and future promises, the cost of this new proposal must be considered within the context of Medicare's existing fiscal responsibilities and costs. For example, the Part A Trust Fund remains financially unstable, Part B premiums have risen dramatically in recent years, and the new catastrophic legislation will increase premiums and income taxes substantially.

Given the aging population and health care cost inflation, Medicare costs will continue to escalate in the future. Because S. 2305 is financed on a pay-as-you-go basis, premiums to cover the cost of the new program will skyrocket or become inadequate very quickly. HIAA supports the objective of S. 2305 to be fiscally responsible and we believe that other public and private financing alternatives that rely on full prefunding of benefits should be closely examined.

Summary

In summary, HIAA believes that S. 2305 will serve as a strong catalyst for further discussion on solving the nation's long term care financing crisis. Specifically, we believe that the incremental recommendations for Medicaid reform and long term care insurance tax clarification should proceed as a necessary component of any responsible financing solution.

And, in designing the structure of a future public and private sector financing arrangement, HIAA believes that more analysis needs to be done to determine the most effective model for a shared responsibility and to determine the most fiscally responsible system over the long run. We need to explore more ways to achieve this balance before settling prematurely on an untested concept.

HIAA believes that the flexibility of private insurance initiatives offers the preferred approach to prefunding long term care for the majority of Americans. Private initiatives also provide maximum choices and flexibility to informal caregivers. And, over time, we believe private insurance will help reduce public spending for this care.

Thank you, Mr. Chairman, for the opportunity to talk with you today. We look forward to an on-going dialogue with you and your staff as the bill moves forward.

The Consumer's
Guide to Long-Term
Care Insurance

HIAA
Health
Insurance
Association
of America

Acknowledgments

We gratefully acknowledge the help in identifying consumer concerns provided by the American Association of Retired Persons staff. Also, we wish to thank the members of the Health Insurance Association of America's Long-Term Care Task Force for their guidance and technical assistance in developing this booklet.

Foreword

Shopping for health insurance can be a very complicated matter. There are always a lot of unfamiliar words and phrases to wade through and differing costs of coverages to understand.

Probably the single most confusing aspect of it all is long-term care. Because contrary to what most people think, Medicare provides only very limited coverage for long-term care. It covers only care of short duration, the kind people may need right after they've been in the hospital. This can either be in a skilled nursing facility or their own home.

What most people aren't covered for—either by Medicare or most private Medicare supplementary policies—is long-term care in nursing homes that serve people who will usually be there for the rest of their days. Medicaid covers this but only after people's savings have become exhausted.

You owe it to yourself to examine carefully all aspects relating to this coverage and its cost. This booklet will tell you in plain language much of what you need to know. I recommend it for your careful reading.

Otis R Bowen M.D.

Otis R. Bowen, M.D.
Secretary
Department of Health
and Human Services

Many people want to know how to buy insurance coverage that will protect them from the potentially catastrophic expenses related to long-term care. However, most people do not know what their chances are of ever needing long-term care services, how expensive these services can be or whether their present health insurance coverage will take care of them.

What is Long-Term Care?

Long-term care refers to the kind of day-in, day-out help that you could need if you ever have a chronic illness or disability that lasts a long time and you are unable to care for yourself. You may never need lengthy care in a nursing home (which most people think is the only kind of long-term care) but it's possible that some day you will need help at home with daily activities such as dressing, bathing, or walking.

To meet a range of long-term care needs, there are many kinds of long-term care services in addition to the care associated with lengthy stays in a nursing home or health care you may need at home. Other services include: adult day care; respite care (which helps family members cope with caring for older persons at home); care given in senior citizens or congregate housing; aide or chore services; and friendly visiting services.

Some or all of these services may be available where you live now or plan to retire. However, this booklet deals mainly with the two kinds of long-term care covered by private long-term care insurance policies that are currently available: nursing home and home health care.

The ***Consumer's Guide to Long-Term Care Insurance*** will also help you gauge whether long-term care insurance policies can help you meet future expenses related to chronic illness or disability. To make this guide easier to understand, technical terms are *italicized* and defined the first time they appear in the text; also, these terms are defined in the Long-Term Care Glossary in the back.

Medicare and Long-Term Care

The fact is that neither *Medicare* nor private *Medicare supplement insurance* (or the health insurance you have through your employer) will pay for most long-term care expenses.

Medicare supplement insurance (Medigap) is private insurance that is designed to help cover some of the gaps in Medicare coverage—but not long-term care. Some retirees are covered by their group health plan which complements Medicare, but these plans generally do not cover long-term care either.

Although you may have Medicare as well as other health insurance, you will be covered for expenses related to only a limited amount of skilled nursing care. ***Skilled nursing care*** refers to the kind of daily nursing and rehabilitative care that can be performed only by, or under the supervision of skilled medical personnel. The care received must also be based on a doctor's orders.

This means you will not be covered if you need the kind of extended, ***intermediate*** or ***custodial care*** associated with long-term nursing home stays or if you need prolonged ***home health care*** on a daily basis.

Intermediate care refers to occasional nursing and rehabilitative care that must be based on a doctor's orders and can only be performed by, or under the supervision of skilled medical personnel. Custodial care is care that is primarily for the purpose of meeting personal needs such as help in walking, bathing, dressing, eating or taking medicine. It can usually be provided by someone without professional medical skills or training.

Home health care may include care received at home such as part-time skilled nursing care, speech therapy, physical or occupational therapy, part-time services of home health aides or help from homemakers or choreworkers.

At present, there are a limited number of long-term care insurance products available that do cover these kinds of expenses. However, insurance companies are developing more products as the demand for this kind of coverage increases.

Will You Need Long-Term Care?

By the year 1990, about 7.7 million Americans over age 65 will likely need some form of long-term care.

But those 85 or older are the most at risk for needing long-term care services. In fact, statistics show that, at any given time, 22 percent of those age 85 or older are in a nursing home.

At the same time, it is estimated that 2 of 5 people age 65 or older risk entering a nursing home. More than half of those will need to stay 90 days or fewer; yet about 40 percent will need to stay on average 2½ years. Only a small number ever stay over five years.

While you may never need nursing home care, home health care or other long-term care services, you still may wish to consider purchasing insurance that covers many of these services because of the risks posed by the need for long-term care and the costs involved.

Insurance, by definition, is a way for you to share the costs of possible economic loss by contracting with an insurance company to assume the risk of such a loss in exchange for a premium.

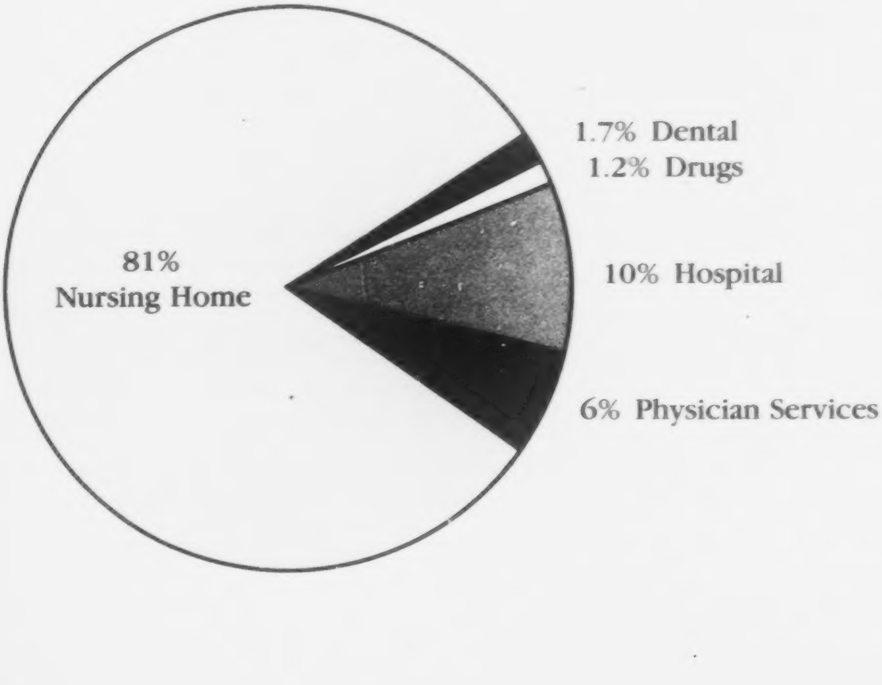
How Expensive is Long-Term Care?

Long-term care can be very expensive. In 1986, a year in a nursing home cost an average of $20,000 to $30,000 (the cost often depending on the area in which the home is located) or about $2,000 per month. At the most expensive nursing homes, the annual cost could be as much as $50,000.

Home health care provided on an unskilled basis (help with grooming or dressing) by a home health aide three times a week for a year can easily cost $440 a month or $5,300 a year. Skilled nursing home care visits can cost even more with three visits per week for a year running as much as $680 a month or $8,200 a year.

It's difficult to know what kind of care you may need or what the costs will be, but knowing you will be responsible for the majority of expenses, you can begin to consider what kind of insurance coverage you need to buy.

Elderly Out-Of-Pocket Expenses over $2,000/Yr



Who Pays for It?

In 1987, over half of nursing home care expenses alone were paid out-of-pocket by individuals or families. Medicare paid for less than two percent of the nation's $41.6 billion annual nursing home bill and private insurance paid even less.

In fact, Medicare will only help pay for:

- Skilled nursing care up to 100 days, and your admission to a facility must be within 30 days of a three-day hospital stay. A physician must show that your admission is necessary.*
- Part-time skilled home health care (but only if you are homebound, a physician certifies the care is necessary and provides a treatment plan and the agency is Medicare participating). This is a very limited benefit and does not cover services you may need on a daily basis over an extended period of time.*

The other primary payer of nursing home care expenses (over 42%) is *Medicaid*, the government program that is meant to provide help with medical expenses to the poor. To qualify for Medicaid, you (or your family) either must already be "poor" or literally impoverish yourself—"spending down" virtually all of your assets (except your house). That happens to about one half of the people who enter nursing homes as "private-pay" patients. A recent study showed that those who pay for nursing home care out of their own pockets are often impoverished within six months to a year. They then must turn to Medicaid (public assistance) to pay part or all of their expenses.

For those over the age of 60, expenses for some home care services are available under the Federal Older Americans Act on a limited basis, such as Meals on Wheels, homemaker and home health aides. If you need such services, contact the local Area Agency on Aging listed in the phone book for more information about them.

What Kind of Insurance is Available?

You can buy private insurance that helps to cover major expenses for long-term care. (See Page 11 for where to write about available policies.) There are a limited number of policies on the market today, but at least one is available in each state. These policies help pay expenses that may pose the highest risk to you.

Almost all available policies are "indemnity" policies, meaning they pay a set amount (usually a certain dollar figure per day) for care in a nursing home or for home health care. No policy, however, provides blanket coverage for all expenses and most policies on the market today do not automatically adjust for inflation. This means a policy's benefits are not necessarily tied to future increases in the costs of long-term care.

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*Legislation currently pending in Congress is expected to change Medicare's present skilled nursing care and home health care benefits. All Medicare beneficiaries will be receiving details from insurers and the federal government once the law goes into effect.

Each policy is priced differently. In 1986, costs ranged from about $100 a year in premiums to more than $2,500, depending on several factors:

Age—In general, the younger you are when you buy a policy, the lower the premium.

Elimination or Deductible Periods—These periods are defined as the number of days you must be confined in a facility or the number of home care visits you must have received before policy benefits begin. Usually, the longer the elimination or deductible period, the lower the premium.

Amount Paid and Duration of Benefits—These vary from policy to policy, but in general, the more money the policy will pay or the longer the benefit period, the more you will pay for the policy. For example, a policy that pays $100 a day for up to five years of nursing home care will cost more than a policy that pays $50 a day for three years.

What Kind of Care is Provided?

Long-term care policies may pay for skilled, intermediate or custodial care in a nursing home. Each policy may define these levels of care differently and the definitions are not the same as Medicare's.

Some policies require you to be hospitalized first before covering nursing home care, and many require that you receive skilled or intermediate care before they will pay for custodial care expenses.

Policies generally pay only for expenses in facilities that:

- Are licensed by the state and participate in Medicaid and/or Medicare; and
- Meet the policy's definition of skilled, intermediate or custodial care.

This is why it's very important for you to find out the kinds of nursing homes in the area in which you live or plan to receive care before you buy a policy. Check the nursing homes in your area to make sure they fit policy definitions. If they don't, you may not be eligible for benefits.

Also, policies often cover home health care services such as skilled or non-skilled nursing care, and homemaker and home health aides although some policies require a prior nursing home or hospital stay before they will cover home health care benefits.

What Kinds of Limits are There?

All policies contain limitations and exclusions in addition to age, elimination or deductible periods, or the amount and duration of benefits. Others you should study before making a purchase are:

Pre-existing conditions—When you apply for long-term care insurance, you may be asked questions about the previous and current state of your health. This is because an insurance company generally requires that a certain period of time pass before the policy pays for care related to a health problem you may have had when you applied. Such health problems are called pre-existing conditions. At this time, most companies use a six-month pre-existing condition limitation period. In some cases, you may be denied coverage because of your health status.

Eligibility—After a certain age, you will be unable to buy a policy. Each company sets its own age limit—usually around age 79. Most policies are only available to those over the age of 55. It's possible that both age limits may change in the future, as new policies are developed and sold.

Renewability—This policy provision is normally found on the first page of the policy. It tells you under what circumstances the policy can be cancelled by the insurance company or how premiums can be raised. Most policies are guaranteed renewable and cannot be cancelled.

Exclusions—Policies may not pay for long-term care related to mental or nervous conditions, alcoholism, mental retardation, or certain other health conditions or situations. However, Alzheimer's disease, and other organic disorders, leading causes of nursing home admissions, are generally covered.

What Kinds of Questions Should You Ask?

Before you consider buying long-term care insurance, you should determine what kinds of resources you have or plan to have to take care of your long-term care needs. For example, do you have savings, life insurance, a pension that would help pay for them? Would other family members help you if necessary or would you qualify for community services that are income-related?

Be sure to read policies you are considering carefully and compare them. Don't be afraid to ask an insurance agent about anything that doesn't seem clear in the policy. There is no one solution for everyone in planning for the future, but your financial plans should include consideration of your long-term care needs.

Here is a table to help you compare and evaluate policies you may wish to consider. Use it as a basis for questioning an insurance agent or for asking questions about promotional literature you may receive in the mail.

	Policy A	Policy B

What Does Long-Term Care Cost?

1. What kinds of nursing homes are there in your area and how much do they charge for:

	Policy A	Policy B
_____ skilled nursing care?	$________ per month	$________ per month
_____ intermediate nursing care?	$________ per month	$________ per month
_____ custodial/personal care?	$________ per month	$________ per month

2. What do home health care agencies in your area charge?

	Policy A	Policy B
_____ unskilled care	$________ per month	$________ per month
_____ skilled care	$________ per month	$________ per month

How Much Does the Policy Pay?

3. What is the maximum amount the policy will pay for:

	Policy A	Policy B
• skilled nursing care	$__________ per day	$__________ per day
• intermediate nursing care	$__________ per day	$__________ per day
• custodial nursing care	$__________ per day	$__________ per day
• home health care	$__________ per day	$__________ per day

How Much Does the Policy Cost?

4. How much will the policy cost you over time?

	Policy A	Policy B
1 year	$______________	$______________
5 years	$______________	$______________
10 years	$______________	$______________
15 years	$______________	$______________

5. Can the company raise your premium over time or under other circumstances?

	Policy A	Policy B
	Yes ☐ No ☐	Yes ☐ No ☐
If so, what are the circumstances?	______________ ______________	______________ ______________

What are the Benefits?

6. Does the policy provide benefits for the following long-term care expenses? If so, check which kind.

	Policy A	Policy B
• skilled nursing care	Yes ☐ No ☐	Yes ☐ No ☐
• intermediate care	Yes ☐ No ☐	Yes ☐ No ☐
• custodial care	Yes ☐ No ☐	Yes ☐ No ☐
• home health care	Yes ☐ No ☐	Yes ☐ No ☐

	Policy A	Policy B
7. For how long will the policy's benefits last?		
- skilled nursing care?	____ days	____ days
- intermediate nursing care?	____ days	____ days
- custodial nursing care?	____ days	____ days
- home health care?	____ days	____ days
- all of the above services?	____ days	____ days
8. Does the policy cover Alzheimer's disease if you developed it after you purchased the policy?	Yes ☐ No ☐	Yes ☐ No ☐
9. Does the policy provide benefits if you need care away from the area in which you live or if you move to another state?	Yes ☐ No ☐	Yes ☐ No ☐
10. Will the policy provide benefits if you have similar coverage with another policy?	Yes ☐ No ☐	Yes ☐ No ☐

What are the Limits?

	Policy A		Policy B	
11. What is the elimination or deductible period before benefits begin?				
- nursing home care	____ days		____ days	
- home health care	____ days		____ days	
12. What is the pre-existing condition limitation period?	____ months		____ months	
13. Can the company cancel or refuse to renew the policy?	Yes ☐ No ☐		Yes ☐ No ☐	
If there are conditions, what are they?	____________		____________	
14a. Is a prior hospital stay required before the policy will pay for:		# days		# days
- skilled nursing care	Yes ☐ No ☐	______	Yes ☐ No ☐	______
- intermediate nursing care	Yes ☐ No ☐	______	Yes ☐ No ☐	______
- custodial nursing care	Yes ☐ No ☐	______	Yes ☐ No ☐	______
b. Is a prior skilled nursing home stay required before the policy will pay for:		# days		# days
- intermediate care	Yes ☐ No ☐	______	Yes ☐ No ☐	______
- custodial care	Yes ☐ No ☐	______	Yes ☐ No ☐	______
c. Is a prior nursing home stay required before the policy will pay for:		# days		# days
- home health care	Yes ☐ No ☐	______	Yes ☐ No ☐	______
15. Are there other limitations or exclusions that concern you?	Yes ☐ No ☐		Yes ☐ No ☐	
- If so, what are they?	____________		____________	

Long-Term Care Glossary

The following definitions of commonly used long-term care terms may differ somewhat from those found in long-term care policies you may consider. In many cases, they also differ from those definitions Medicare and Medicaid use:

Skilled nursing care is daily nursing and rehabilitative care that can be performed only by, or under the supervision of, skilled medical personnel. The care received must be based on a doctor's orders.

Intermediate care is occasional nursing and rehabilitative care that can only be performed by, or under the supervision of, skilled medical personnel. The care received must be based on a doctor's orders.

Custodial care is care that is primarily for the purpose of meeting personal needs such as help in walking, bathing, dressing, eating or taking medicine. It can be provided by someone without professional medical skills or training, but must be based on a doctor's orders.

Home health care may include care received at home such as part-time skilled nursing care, speech therapy, physical or occupational therapy, part-time services of home health aides or help from homemakers or choreworkers.

Skilled nursing facility is one licensed by the state and one that may be certified by Medicare and/or Medicaid to provide skilled nursing care. It may also provide intermediate or custodial care.

Intermediate care facility is one that is licensed by the state and one that may be certified by Medicaid to provide intermediate care. It may also provide custodial care. It can provide Medicare or Medicaid-covered skilled nursing care only if it has been certified to do either one.

Medicaid is the joint state and federal program that states have adopted to provide payment for health care services to those with lower incomes or with very high medical bills. It does provide benefits for custodial and home health care, once income and assets have been "spent down" to eligibility levels.

Medicare is the federal program that is designed to provide those over age 65, some disabled persons and those with end-stage renal disease with help in paying for hospital and medical expenses. It does not provide benefits for long-term care.

Medicare supplement insurance (Medigap) is private insurance that supplements or fills in many of the gaps in Medicare coverage. It does not provide benefits for long-term care.

Who Offers Long-Term Care Insurance?

There are policies available now in every state and many companies are in the process of developing policies.

You may wish to contact your state insurance department or insurance agent for more information. Or, for a list of private insurers offering products in your state, write to:

Health Insurance Association of America
Information Services
1001 Pennsylvania Avenue, N.W.
Washington, D.C. 20004-2599

Additional Reading

Additional publications about health care coverage and long-term care are available to older Americans or their adult children from government agencies and other organizations.

American Association of Homes for the Aging
1129 20th Street, N.W.
Washington, DC 20036
Telephone: 202/296-5960

Brochures describing continuing care communities.

American Association of Retired Persons
Health Advocacy Services
1909 K Street, N.W.
Washington, DC 20049
Telephone: 202/872-4700

Booklets and pamphlets on long-term care choices for older Americans.

American Health Care Association
1200 15th Street, N.W.
Washington, DC 20005
Telephone: 202/833-2050

Various pamphlets about long-term care facilities.

Council of Better Business Bureaus
1515 Wilson Boulevard
Arlington, VA 22209
Telephone: 703/276-0100

Written materials on home care and nursing homes.

Health Insurance Association of America
1001 Pennsylvania Avenue, N.W.
Washington, DC 20004-2599
Health Insurance Hot-Line:
1-800-423-8000

Booklets on health insurance in general and how private insurance works with Medicare. Health insurance hotline.

National Consumers League
815 15th Street, N.W.
Suite 516
Washington, DC 20005
Telephone: 202/639-8140

Consumer's guide to life care communities have health and ambulatory factsheets on Medicare.

National Council on the Aging
600 Maryland Avenue, S.W.
West Wing, Suite 208
Washington, DC 20024
Telephone: 202/479-1200

Several guides concerning long-term care and Medicaid, community resources, housing options and long-distance caregiving.

State Insurance Departments

Some have consumer education programs for older Americans about a range of insurance-related topics, including Medicare, Medicaid, Medigap, and long-term care insurance. Contact the department in your state for further information.

Social Security Offices
(Most Cities)

Several publications including ***Your Medicare Handbook*** as well as brochures, pamphlets on Medicaid, and other government programs for the elderly.

STATEMENT BY
SENATOR JOHN H. CHAFEE
AT
HEARING ON
S. 2305, LONG TERM CARE ASSISTANCE ACT OF 1877
ON
JUNE 17, 1988

MR. CHAIRMAN, I COMMEND YOU FOR HOLDING THIS SECOND HEARING ON S. 2305, THE LONG-TERM CARE ASSISTANCE ACT OF 1988. I AM PROUD TO BE A COSPONSOR OF THIS LEGISLATION AND AM GLAD TO HAVE THE OPPORTUNITY TO HEAR ADDITIONAL COMMENTS ON HOW WE MIGHT IMPROVE OUR BILL.

EVERY DAY I RECEIVE LETTERS AND CALLS FROM RHODE ISLANDERS CONCERNED ABOUT THE GAPS IN OUR HEALTH CARE SYSTEM. THE BIGGEST FEAR OF OUR SENIOR CITIZENS IS HAVING TO DEPLETE THEIR LIFE SAVINGS ON THE HIGH COST OF PRESCRIPTION DRUGS AND LONG-TERM CARE. THE CATASTROPHIC ILLNESS PROTECTION ACT THAT THE SENATE PASSED LAST WEEK IS A POSITIVE FIRST STEP TOWARD ADDRESSING THESE PROBLEMS AND PROVIDING MORE COMPREHENSIVE LONG-TERM CARE FOR OUR ELDERLY POPULATION.

BUT WE HAVE A LONG WAY TO GO. I RECENTLY HELD A HEARING IN RHODE ISLAND THAT FOCUSED ON HOME HEALTH CARE SERVICES AND LONG-TERM CARE. THE TESTIMONY REINFORCED MY BELIEF THAT MOST PEOPLE DO NOT WANT TO LIVE IN AN INSTITUTION OR NURSING HOME, OR GO TO THE HOSPITAL EXCEPT AS A LAST RESORT. PEOPLE WANT TO LIVE IN THEIR OWN HOMES, WITH THEIR FAMILIES, FOR AS LONG AS POSSIBLE. THERE IS CURRENTLY AN INSTITUTIONAL BIAS THAT PERVADES OUR ENTIRE HEALTH CARE SYSTEM IN THE UNITED STATES. OUR SYSTEM SEEMS TO SAY THAT IF YOU ARE REALLY SICK AND NEED HELP YOU WOULD BE IN A HOSPITAL OR NURSING HOME RATHER THAN LIVING AT HOME. NOTHING COULD BE FURTHER FROM THE TRUTH.

I BELIEVE THAT IF WE ARE INTERESTED IN TRULY ASSISTING THE ELDERLY WHO FACE A SERIOUS ILLNESS, WE MUST RESTRUCTURE AND EXPAND

OUR EXISTING PROGRAMS TO PROTECT THE FINANCIAL INDEPENDENCE OF THE ELDERLY AND PROVIDE A BROAD RANGE OF COMMUNITY AND HOME-BASED SERVICES TO HELP THEM REMAIN IN THEIR OWN HOMES FOR AS LONG AS POSSIBLE. AND PROVIDE ACUTE CARE, INSTITUTION BASED SERVICES WHEN NECESSARY.

THE LONG-TERM CARE ASSISTANCE ACT MEETS THESE GOALS. IT EXPANDS THE MEDICARE PROGRAM AND PLACES THE EMPHASIS WHERE IT BELONGS -- ON PROVIDING SERVICES IN THE HOME. RESPITE CARE AND HOME HEALTH CARE WILL BE AVAILABLE WHEN THEY ARE NEEDED. HOWEVER, THIS EMPHASIS IS NOT CREATED AT THE EXPENSE OF MORE INTENSIVE NURSING HOME CARE. OUR PROPOSAL WILL PROVIDE FINANCIAL ASSISTANCE FOR NURSING HOME CARE AFTER A TWO-YEAR EXCLUSIONARY PERIOD. THIS WILL ENABLE EVERY INDIVIDUAL TO PLAN FOR THE FUTURE BECAUSE THEY WILL KNOW IN ADVANCE WHAT THEIR FINANCIAL LIABILITY WILL BE IN THE WORST CASE SCENARIO.

BECAUSE OUR PROPOSAL WOULD CREATE A DEFINED RISK, WE HOPE IT WILL ENCOURAGE PRIVATE INSURANCE COMPANIES TO BEGIN TO OFFER LONG-TERM CARE COVERAGE. INDEED, IN ORDER FOR THE SYSTEM TO BE SUCCESSFUL, PRIVATE SECTOR INVOLVEMENT IS ESSENTIAL.

IN OUR DISCUSSIONS TODAY WE MUST REMEMBER ALSO THE CHRONICALLY ILL POPULATION UNDER 65. MANY OF OUR NATION'S CHILDREN ARE WITHOUT THE HEALTH CARE THEY SO DESPERATELY NEED. MORE THAN ONE THIRD OF THOSE WITHOUT ANY HEALTH CARE INSURANCE LIVE IN FAMILIES WITH INCOMES BELOW THE POVERTY LEVEL, ANOTHER ONE THIRD LIVE IN FAMILIES WITH INCOMES BETWEEN 100 AND 200 PERCENT OF THE POVERTY LEVEL. FOR FAMILIES WITH A CHRONICALLY ILL CHILD, EVEN IF THEY DO HAVE PRIVATE HEALTH INSURANCE, THEIR PERSONAL SAVINGS AND INSURANCE BENEFITS CAN BE QUICKLY EXAUSTED. THEY HAVE NOWHERE TO GO BUT INTO POVERTY TO QUALIFY FOR MEDICAID BENEFITS.

OUR HEALTH CARE SYSTEM IS A PATCHWORK OF PROGRAMS WITH MANY HOLES THROUGH WHICH MILLIONS OF PEOPLE ARE FALLING. S. 2305, THE SUBJECT OF OUR HEARING TODAY, FILLS ONE OF THOSE GAPS.

STATEMENT
# of the
AMERICAN ASSOCIATION OF RETIRED PERSONS

Thank you, Senator Mitchell. My name is Louise Crooks, and I am the President of the American Association of Retired Persons (AARP). On behalf of the more than 29 million members of AARP, I want to commend you for your strong and positive leadership on the issue of long-term care. As with your efforts to improve quality of life in nursing homes, to prevent impoverishment of the spouses of nursing home residents and to add a prescription drug benefit to Medicare, I believe your serious attention to comprehensive long-term care will spark productive legislation. The Association is pleased that your long-term care bill begins to move this critical need from a welfare-based to an insurance based system.

There are few catastrophes which can strike a family that lead to greater financial and emotional devastation than a long-term disabling illness. And there are few for which society offers so little help. Our country's only long-term care program, Medicaid, is a welfare program which often robs families of dignity and independence. Our society is already paying the costs of long-term care, but in a way that places inordinate burdens on the victims of chronic illness and their families. The issue for federal policy is how to spread the burden so that the costs to any one person will be small, while offering protection and appropriate care to all. The answer will be found in a social insurance rather than welfare approach.

I will focus my remarks on four areas: (1) eligibility requirements; (2) review/case management; (3) home and community-based benefits; and (4) nursing home benefits.

ADMINISTRATION

Eligibility

Long term care is potentially needed by persons of all ages, not just the elderly. Seven million American households today have a child or adult member who is chronically ill or disabled. Millions of chronically ill children and adults who need long-term care are outside of the current

Medicare/OASDI system and not covered under private insurance. The lack of coverage of in-home and community services, in particular, poses enormous burdens for these families. The Association recognizes that providing long-term care coverage for these groups under Medicare will raise the overall cost of the program, and we hope that we will have the opportunity to propose possible financing sources during future hearings on this topic.

I want to stress that the Association and its leadership are reluctant to expand long-term benefits for the elderly without also addressing the needs of the young. These individuals are our children and our grandchildren, and we are as concerned about the burdens being placed on families of chronically ill children as we are about the burdens being placed on families caring for frail older relatives. We hope that you will give serious consideration to expanding your proposal to include these younger groups in order to stimulate national debate on this issue.

The Association concurs with your decision to base eligibility for benefits on cognitive as well as functional impairments. Because the definitional issues are complex, we recommend that an expert commission be established to assist the Secretary in refining eligibility criteria and in developing a national, uniform assessment scale. How, for example, will inability to perform activities of daily living (ADLs) without human assistance be measured? How will fluctuations in an individual's ability to perform certain activities at different times of the day or in different settings be rated? What training will be needed by those conducting the assessments? It will also be critical for such a commission to examine who would and would not be included under the definition of functional impairment specified in the bill and to assess various measures of cognitive impairment.

Review/Case Management

The process of case management seems to hold the best promise for both helping individuals secure services most appropriate to their needs and controlling any inappropriate utilization. The states with the most comprehensive long-term care programs have found that providing for individual needs assessments by independent case management agencies allows government to meet long-term care needs in a cost-effective manner.

The bill would establish "eligibility review organizations" to determine eligibility for benefits under the program. It is not clear whether these organizations would also coordinate services for individual clients, contract with providers to deliver care, and monitor the quality of care provided, all of which are important case management functions.

It is noted that the Secretary of HHS would certify and contract with agencies or organizations for case management services. We are not certain if this provision would take full advantage of states' experience in administering long-term care services provided under Medicaid, the Older Americans' Act, the Social Services Block Grant(SSBG), and other programs. Because states have a "track record", we believe they should be given a significant role in the administration of the new program with appropriate federal oversight. Both service delivery systems and the profiles of long-term care populations vary widely between and within the states, and states will need to have the flexibility to tailor programs to meet their distinctive needs. In a poll conducted for AARP and the Villers Foundation this past summer, voters indicated by a 5 to 3 margin that they would prefer a federally funded long-term care program administered at the state rather than the federal level.

In determining eligibility for the program, in-person assessments and interviews with caregiver(s) will be critical to gathering accurate information about individuals' functional and health status, social supports, and preferences about living and service arrangements. And in developing care plans, it will be critical to focus on individuals' strengths rather than weaknesses in order to maximize their independence. The provision in the bill which would permit eligibility determinations to be limited "in appropriate cases (as determined by the Secretary) to a review of documents" could encourage paper reviews leading to inaccurate and inequitable coverage determinations. Even in exceptional circumstances, such as when individuals are both bedridden and cognitively impaired, we believe they should have the right to discuss their needs and preferences directly with case managers. Similarly, case managers should be required to discuss coverage determinations with beneficiaries and to give them some choice in providers.

The "eligibility review organizations" would be required to notify applicants of their eligibility within 60 days, a period we think is far too long. Older persons experiencing a major illness or other life crisis cannot wait that long for a decision.

We welcome the language in the bill entitling beneficiaries to appeal decisions made by the eligibility review organizations, and the fact that benefits will be continued beyond the reconsideration and administrative law judge stages. We would favor an additional stipulation that the reconsideration decision be made by someone other than the individual or individuals who made the initial denial. Further, we would urge continuation of benefits through one additional level of review, i.e., a Bureau of Hearings and Appeals ruling.

PROGRAM BENEFITS

We are pleased that the bill encompasses in-home as well as institutional care services, but are concerned that the benefit package for home and community services is not broad enough, and that many older Americans will find the two-year deductible period for nursing home benefits very burdensome.

Home & Community Care

The bill would add homemaker and chore aide services to current Medicare home health benefits. The Association believes that a broader array of home and community-based services should be covered under the bill, including adult day care, transportation, companion services, home-delivered meals, and home adjustment equipment. Since the bill is intended to provide the maximum opportunity for older persons to remain in their own homes as long as possible, it will be critical to give case managers flexibility in arranging services to meet individual needs. In addition, case managers must be able to substitute less costly, non-medical services whenever appropriate. In some cases, for example, companion services may be less costly and equally as effective as homemaker/chore aides. And it may be less costly to provide home-delivered meals to a homebound person than to pay a homemaker/aide to cook and prepare meals. Adult day care can also cost less than the one-to-one provision of home health care. For example, in South Carolina's Medicaid waiver program, an adult medical day care package, including physical therapy as well as personal care, meals, and other services, costs $40 per day compared with a $60 charge for one physical therapy session in the home.

Evidence suggests that providing a broader array of services would not lead to significantly higher costs. In the channeling project demonstration sites where case managers were able to purchase a very wide range of services to meet client needs, services such as those mentioned above represented only 14% of average monthly expenditures per client. The services to be covered under the bill, including homemaker/personal care aides, skilled nursing care, and home health aides, represented 86% of these monthly costs. Thus, while cost savings might not be achieved by adding new services, these data suggest that any cost increase would be small. Yet such services can make a crucial difference in maintaining independent living. A broader service package would also maximize individual case managers' creativity in arranging service packages and give consumers more choice.

Language needs to be added to the bill to assure that the post-acute services currently covered under Medicare--home health care, hospice, and skilled nursing facility (SNF) care--will not be reduced or duplicated under the new benefit. We would recommend that the current program be the primary payer in situations where a person is eligible for benefits under both this program and current Medicare post-acute services. It will be important to assure that new home care benefits be permitted to supplement current Medicare benefits, without jeopardizing coverage under either program. We also believe that currently covered Medicare SNF days should be counted toward the 2 year deductible for institutional care.

AARP is concerned that the $500 deductible for home care benefits will be a barrier to the use of such services by lower and middle income individuals. Upper income individuals would have incentive to purchase high cost services in order to meet the deductible in less than one month. In contrast, many poor and middle income persons could not meet the deductible for a much longer period, or might forego needed services. It is important to underscore that the disabled elderly living in the community are more likely to be poor. While those below the official federal poverty line would be protected due to the Medicaid buy-in provision in the bill, those just above the poverty line would be hard pressed to meet the deductible. Recent data from the 1984 Supplement on Aging of the National Health Interview Survey indicate that elderly persons with incomes between 100-149% of poverty are more likely to experience ADL limitations (28%) than those whose incomes exceed 200% of the official poverty line (18%). Yet another problem with a dollar deductible is that it does not reflect regional variations in the cost of home care services.

The bill limits home care services to those provided in a place of residence used as a individual's home. Because board and care homes and supportive housing arrangements often house large numbers of severely disabled persons, we favor language that explicitly includes these settings.

The Association is pleased that the payment cap will be determined on an annual rather than a monthly basis. Many community care coordinators report that costs are almost always higher during the initial period of eligibility, which often follows an acute health care crisis or hospitalization and when patients need more intensive rehabilitation and support. Annualized costs should allow for variation in client needs over time. In addition, consideration should be given to determining if there are particular groups of beneficiaries who have extraordinary needs and whose costs should be permitted to exceed the cap, e.g. up to 90-100% of the cost of SNF care.

Respite Care

Happily, we anticipate enactment of catastrophic legislation which will include a modest respite care benefit. Experience gained from that benefit will be instructive for the manner in which respite care is fully implemented in comprehensive long-term care legislation. We believe that given the proposed expansion of home care benefits in the Mitchell bill, respite care would more appropriately be listed as one of the services available, rather than as a separate benefit. Respite care defines the goal of care—which is to provide short-term relief to caregivers--rather than the service itself. It may be provided in a variety of settings, e.g.,the home, an adult day care center, nursing home or hospital.

As drafted, the bill would require a 50% copayment for respite care services up to a maximum of $2,000 per year. Medicare beneficiaries would be eligible if they reside with one or more family members who provide unpaid assistance in the performance of 2 or more ADLs. We are not certain how this provision would be differentiated from the homemaker/chore benefit, in which persons with 2 or more ADL depndencies would be eligible for homemaker services following an annual deductible of $500 per year and a 20% copayment thereafter. For those who have a caregiver, homemaker assistance would represent both a home care benefit and a respite benefit. Would the beneficiary pay a 20% or 50% copayment? Another possible problem with the proposed benefit structure is that it would not be fair to deny home care benefits to otherwise eligible persons simply because they have a family caregiver available. Since we recommend adding day care to the list of covered community services, we see little reason for a separate respite care benefit for in-home or day care.

In order to make the program cost-effective and to encourage continued family support, case managers should make efforts to arrange informal services before authorizing formal services. At the same time, the program must recognize the stresses experienced by family caregivers and their need for relief. Thus, the legislation should specify that providing relief to caregivers is a legitimate reason for case managers to authorize home care or day care services for beneficiaries who meet the eligibility criteria. Since respite care would fall under the cap on allowable costs, and because there is wide evidence that caregivers underutilize those respite care services which are available, this change would not lead to significantly higher costs, and perhaps to cost savings.

Nursing Home Benefits

We have very serious reservations about the distributional effects of the two year deductible period for nursing home care. Data from many sources show that the great majority of nursing home residents would "spend down" onto Medicaid before the deductible is met and would not benefit from this aspect of the program. Instead, the likely beneficiaries would be upper middle and upper income individuals. We question whether it is wise social policy to allow new public dollars for this benefit to accrue primarily to those who are most able to pay, particularly when Americans of all economic status will be asked to contribute toward the costs of the program.

In considering the impact of this proposal, it is important to remember that nursing home residents are disproportionately poor, female, single, and old. According to the 1985 National Nursing Home Survey, persons aged 75 and over account for 84% of all residents, and persons aged 85 and over for 45%. Three-quarters are women, and 89% are unmarried (widowed, divorced, or never-married.)

Currently, 40% of nursing home residents rely primarily on the Medicaid program to pay for care in the first month of a nursing home stay. According to an analysis conducted for the House Aging Committee, 67% of persons aged 65 and over would deplete both their income and financial assets within one year of nursing home care. The recently published Brookings study indicates that the median income and financial assets of those aged 65-74 in 1986-1990 (about $32,000) is just barely sufficient to meet the cost of one year of nursing home care, which averages around $24,000 per year. The average for those aged 75-84 (about $18,000) would not be sufficient, and that of those aged 85 and older (about $13,000) is only about half of what would be required to meet a one year deductible.

Because the vast majority of nursing home admissions (72%) are under two years, the vast majority of those who need such care would not be eligible for the new benefit. The primary beneficiaries would be the minority whose length of stay exceeds two years and who do not become eligible for Medicaid within this period--those in upper income groups. While lowering the deductible period to one year would be an improvement, it is also important to note that 63% of nursing home admissions are under one year.

Another serious concern is that the structure of the proposal will risk retaining the current "two-class" system of care under which Medicaid patients have difficulty obtaining access to nursing home care. Since the bill does not affect certificate of need limitations and bed shortages, providers will be able to pick and choose among the highest bidders. As in the case of hospital "dumping", nursing home providers may try to minimize admissions for uninsured beneficiaries. In addition, the approach will perpetuate and possibly exacerbate the two-tiered delivery problem, where private pay and insured residents receive better food, private rooms, and additional amenities compared to Medicaid beneficiaries. Finally, prescreening of nursing home applicants, as called for in the bill, is critical but problematic with a 2 year waiting period.

If our nation is to achieve a cost-effective long term care system which addresses the needs of our most vulnerable citizens, public sector coverage for nursing home care must be comprehensive, as opposed to providing solely "front-end" or "back-end" protection. While we have very serious concerns about providing coverage only after the two year mark, we also have reservations about providing such coverage for only 6 months. Each approach has different strengths and weaknesses, but both risk setting up two tiered systems of care, creating perverse incentives, and having a number of unintended consequences.

THE ROLE OF PRIVATE INSURANCE

Since the role of private insurance will be addressed in a future hearing, we will comment on this aspect of the bill only briefly. By providing for a very substantial deductible period, the bill apparently assumes that a substantial proportion of the elderly would and could purchase private long-term care insurance to protect themselves during this period. This assumption, however, ignores the limitations of the private insurance marketplace. First, for many older persons, the premiums for a policy that would adequately cover the deductible period may be unaffordable. Moreover, the Brookings study has shown that those who are able to purchase such policies are not, by and large, the same people at the greatest risk of institutionalization.

Second, private insurers cannot sell to those with potentially disabling medical conditions and those who are at high risk of needing such care. Unlike a more comprehensive approach, the bill offers virtually no protection to the hundreds of thousands of elderly persons with pre-existing conditions.

Third, private insurance is essentially unavailable to the old old. Most insurers do not offer policies to those over age 80 or 85, or, if they do, the prices are very high. We should not develop a new, public/private long-term care program that ignores those most in need.

And, even if one assumes that a substantial majority of the elderly can afford private policies (which we think is a very generous assumption), this does not necessarily mean that such policies will provide sufficient protection to prevent most residents from spending down onto Medicaid prior to the two year mark. Policies typically have a variety of limitations which reduce the protection they offer, such as prior hospitalization requirements and indemnity levels that do not increase with inflation. While it is true that the newer generation of policies is providing somewhat better protection, the inability of insurers to adequately predict future utilization patterns will mean that they will move forward cautiously.

CONCLUSION

The Association welcomes this serious proposal to reform our nation's long term care system, and we look forward to working with members of this Committee in improving it. We share the Committee's concerns that any proposal must be fully funded and not add to the federal deficit, and hope to have the opportunity in future hearings to propose financing options which would permit more comprehensive nursing home coverage as well as coverage for younger Americans.

STATEMENT OF

Richard E. Curtis

on

Long Term Care Insurance

Mr. Chairman, my name is Richard E. Curtis and I am President of the Center for Health Policy Development and in that capacity, serve as Executive Director for the National Academy for State Health Policy. The Center is a non-profit organization recently established to encourage the development of innovative financing and delivery strategies to improve health outcomes. A principal function of the Center is to provide analysis and staff support to the Academy, which has been formed to bring together the best state policy and operational expertise to analyze health and long-term care issues, and develop strategies that will improve accessibility, quality and affordability. Each of the Academy's standing committees are composed of accomplished individuals from a range of agencies, including insurance commissions, aging and Medicaid agencies, health departments and state university health policy institutes.

Mr. Chairman, your leadership in seeking a substantually improved and workable federal role in long-term care financing is to be commended. I appreciate the opportunity to provide information that I hope will be useful to you and other members of your subcommittee as you further consider the role of private long-term care insurance vis-a-vis the roles of federal and state government.

My comments will focus on the potential for long term care insurance of case management systems and concepts developed by states, and are largely based on a report for the John A. Hartford Foundation developed by myself and Ed Neuschler of the National Governors' Association Center for Policy Research (where until recently I was Director of Health Policy Studies) and Diane Justice of the National Association of State Units on Aging. You may also wish to consider the potential of such state systems and concepts for further refinement in the structure of benefits under your bill.

Largely in response to the growing awareness that long-term care is the leading cause of catastrophic health care cost for the elderly, a market for private LTC insurance is emerging. The number of insurance companies known to be offering such products has grown from 16 in 1983 to around 80 earlier this year, while growth in the number of policies in force has been from about 150,000 to 500,000 during the same period.

As the structure of your bill recognizes, however, elderly persons do not just want to protect their assets from being depleted by an extended nursing home stay. They generally express a strong preference to remain in their own homes if at all possible. This preference is reflected in market pressure on insurers to develop and offer policies that cover long term, supportive care in the client's home as well as institutional care. The major question facing insurers interested in meeting this demand is how to design products that will provide the services people want at premiums they can afford.

Many states have wrestled with essentially the same issue, as they have designed alternative home and community based care systems to maintain low-income elderly in need of Long Term Care in their own homes, and thus avoid or at least delay placement in nursing homes at greater public expense. In virtually every case where a state has successfully implemented such a system without signficiant LTC cost increases relative to growth in the elderly population, case management has been a critical element. Is is used to: assess clients' need for care under state guidelines; identify and coordinate the multiple services often needed by frail elderly; authorize the amount and type of services which will be covered under an individual's plan of care; and control the total cost of such individual care plans while making a broad array of alternative services available to best meet an individual's specific needs..

Because our country's experience in developing and financing such home based long term care systems has been through state programs, it is sensible to ask whether and how insurers or their clients could benefit from state experiences in developing LTC products. A recent initiative in Washington

State provides an important example for potential public and private sector partnerships in this arena. Blue Cross of Washington and Alaska has contracted with the same network of local LTC case management agencies used by the state for its public LTC programs to perform needs assessment, to develop plans of care, and recommend whether or not to activate benefits for its LTC insurance plan, "Lasting Care". Many program standards and definitions developed by the state to govern case management under public programs are being adopted or adapted by Blue Cross.

The Blue Cross/Washington State initiative illustrates the potential for private insurers to benefit from the state experience in developing and financing community based LTC systems, and provides an example of how the public and private sectors can each further their own objectives through collaboration. It specifically exemplifies, at least in part, the most direct and extensive use that insurers (or the federal government) could make of state LTC experience: contracting with the state developed system. It should be noted that Washington State has developed one of the most comprehsnvie statewide systems of publicly financed community care systems in the country. Other such states include Maine, Oregon and Arkansas.

In the context of current federal program structures, an important question for state policy is whether the Blue Cross/Washington State initiative could be replicated elsewhere or, more generally, how private LTC insurance plans could benefit from state home and community based LTC experience. To explore these question, a day-long symposium was convened in Janaury 1988. Symposium participants, chosen for their individual expertise in LTC issues, included insurers (both Blue Cross and commercial), state and local LTC program managers, private consultants and researchers, and a consumer group staffer.

A brief summary of the insights provided by individual expertise and collective interaction of symposium participants follows. In general, insurers are under strong market pressure to develop LTC products that cover home care, but most insurers do not have in-house expertise or previous experience of their own in this area. Thus, insurers at the symposium generally expressed great interest in learning what they could from state LTC experience. They were not interested in approaches that had not yet proved their worth in the field, but they did want hard information about what technologies had worked.

Because insurers do not know where to find information on state LTC program elements and technologies that might be useful to them, a national clearinghouse on "best practices" in home and community based LTC was suggested. Many examples of state-of-the-art practice exist, but no one person or organization knows about all of them. Such a clearinghouse was also seen as greatly benefiting public program managers in states where alternative LTC programs are not yet well developed and as potentially invaluable to a federal LTC program.

While many elements of such state LTC programs might be useful to insurers, the discussion at the symposium focused largely on case management functions, i.e., client authorization, care planning and coordination. (Those current insurance plans that do provide substantial coverage of home care benefits typically leave it up to the client to find the covered services.)

One traditional function of case management in which insurers are very interested is assessing the client's need for care. Care planning and coordination is the other case manaagement role of interest to insurers. There are two ways of viewing this aspect of case management: as a benefit to the client and/or as a risk/cost management tool for the payer. Help with locating and organizing care is something potential clients are aware they will need and want their insurance policy to cover. Insurers indicated they would plan to market case management as a benefit to the client, even if they also plan to use it for risk/cost management purposes.

A major dialogue ensued over whether case management is an effective risk management tool. Although insurers present were not fully convinced that case management can control utilization of LTC services, state officials generally expressed satisfication that case management has allowed them to affordably offer home and community based services to state program beneficiares.

Concern was expressed by some insurers that the current state of the case management art is too subjective and non-standardized to project expected utilization and develop actuarially sound rates. Further, some insurers fear, the perceived subjectivity would make them liable to lawsuits from clients dissatisfied with their care plans. A clear agreement was not reached on this issue. Practitioners' response to these concerns differed for the two main aspects of case management. The technology for assessing client functional status is relatively well developed, it was noted. Several instruments are available; and high degrees of inter-rater reliability have been reported, once appropriate training has been given. While care planning was seen as more variable and subjective, this was viewed as appropriate to meet individual client circumstances and needs.

Several reasons were offered as to why an insurer might want to buy into an existing case management system developed by a state (as in Washington State). Significant start-up costs would be required for a separate system and, since service volume is expected to be quite low in the early years of a new LTC product, sharing a system offers economies of scale. Insurers may value access to the local provider network, and clients may be less likely to feel that an independent case manager has a financial incentive to deny benefits. However, insurers would not even consider contracting for case management services provided directly by a state agency because they believe that potential clients would not buy such a product. Instead participants discussed a system, similar to that used in Washington State, under which both the state financed public LTC system and private insurers offering LTC products would use the same local case management agency to assess clients' need for care and arrange services. Blue Cross plan officials generally thought a joint statewide system similar to that in Washington State (i.e., using the same local case management agency) might be a possiblity. Commercial insurers were more skeptical and raised the question of whether any state-based system could be sufficiently uniform nationally to meet the needs of national insurers. The development of a public/private partnership to enhance continuity between public and private systems was encouraged by state officials. Noting that, to date, LTC systems development has been accomplished largely by states, they urged insurers not to try to re-invent the wheel, especially since insurance is not going to replace state LTC programs; rather, they will operate on parallel tracks with much interaction.

Because many states do not have fully developed, statewide, comprehensive case management systems in place, an initiative like that in Washington State is not possible everywhere. States wanting to promote joint public/private case managed community care systems should enter into a dialogue with insurers early on in order to reach mutually acceptable resolution of a number of issues. Significant economies and efficiencies and a more rational system may be possible for both the public and private sectors if they talk about the desirable specifications and characteristics of case management organizations and about issues such as definition the insurable event (i.e., assessing need for care).

Another major topic for discussion was the need for data. A critical element in developing a LTC insurance plan is estimating likely utilization of benefits and associated costs in order, first, to determine whether marketing a product is feasible given its probable cost and, second, to develop the precise premium structure. Because little or no long term care coverage has been available (outside of the means tested Medicaid program), little information about the potential use of home care services under LTC insurance has been available to date. As states have expanded coverage of in-home supportive servics for persons in need of LTC they have begun to acquire significant amounts of data on use and cost of in-home and community based services. However, few state data systems are structured in such a way as to readily provide information directly useful to private insurers.

Another approach, more directly applicable to an insured environment, would be to provide immediate coverage of older (80+), very high risk individuals. Given how heavily underwritten current insurance products are and how few insureds are likely to use services over the next decade, it would otherwise be many years before we would know what utilization is going to look like and how well case management works. One way to compress the time frame would be to initiate a demonstration project that covers older and higher risk clients now. It would get them into the system and using services so that utilization data would be available very quickly. Coverage could be provided through several different financing and delivery structures to offer insights on the cost and use implication of alternative system designs.

Mr. Chairman, the development of major improvements in this country's financing and delivery of long term care is both greatly needed and immensely challenging. A large part of that challenge will be to strike the appropriate balance between public and private sector responsibilities, and determine the government roles that can be best performed at the federal and state levels.

I hope that the information we have provided is useful to you and your subcommittee as you further refine your strategies.

TESTIMONY OF THE HONORABLE HAL DAUB
BEFORE THE SENATE FINANCE HEALTH SUBCOMMITTEE
LONG TERM HEALTH CARE HEARING
MAY 27, 1988

MISTER CHAIRMAN AND MEMBERS OF THE HEALTH SUBCOMMITTEE:

I APPRECIATE THE OPPORTUNITY TO PARTICIPATE TODAY IN THIS DISCUSSION OF WHAT CAN ONLY BE CALLED THE AMERICAN LONG TERM HEALTH CARE CRISIS.

SURELY, ALL PRESENT WILL AGREE THAT FEW ISSUES ARE MORE DESERVING OF CONGRESS' ATTENTION THAN THE SKYROCKETING, BANK-BREAKING COSTS OF LONG TERM CARE.

RECENT ESTIMATES INDICATE THAT OVER 80% OF HEALTH CARE EXPENSES INCURRED BY THE ELDERLY RELATE DIRECTLY TO LONG TERM CARE AND NURSING HOME COSTS.

FURTHER, IT HAS BEEN SHOWN THAT WHILE EIGHT OUT OF TEN SENIOR CITIZENS ARE PROTECTED FROM ACUTE, HOSPITAL-RELATED HEALTH COSTS, A FULL NINE OUT OF TEN HAVE NO PROTECTION FROM LONG TERM CARE EXPENSES.

THIS DEPLORABLE SITUATION IS AS UNNECESSARY AS IT IS SAD. OLDER AMERICANS SHOULD NOT -- INDEED, MUST NOT -- BE FORCED TO MAKE THAT LAST TERRIBLE CHOICE BETWEEN BANKRUPTCY AND AN IGNOMINIOUS DEATH.

AND SO WE AS RESPONSIBLE LEGISLATORS ARE FACED WITH A DILEMMA: HOW ARE WE TO ADDRESS THIS PROBLEM WHILE PRESERVING SOUND FISCAL POLICY?

TO DATE, MOST MEMBERS OF CONGRESS HAVE RESPONDED TO THIS CHALLENGE WITH PROPOSALS OF ENTITLEMENT EXPANSIONS FUNDED BY TAX INCREASES; IN FACT, ADDITIONS TO MEDICARE AND INCREASED TAXATION HAVE BEEN ADVOCATED BY SOME AS THE SOLE MEANS OF AMENDING OUR NATION'S HEALTH CARE INADEQUACIES.

A CASE IN POINT IS THE ACUTE ILLNESS COST CONTAINMENT BILL RECENTLY ISSUED BY THE HOUSE-SENATE CATASTROPHIC CONFERENCE COMMITTEE. HERE, MISTER CHAIRMAN, IS LEGISLATION WHICH PROMISES TO COST $45 BILLION DOLLARS BY 1992, BURDEN THE MANY WITH OUITLANDISH NEW TAXES, AND HELP THE FEW -- ALL IN THE INTEREST OF PROVIDING SENIORS WITH BENEFITS THEY IN MOST CASES ALREADY HAVE AND IN MANY CASES SIMPLY COULD DO WITHOUT.

NOW IS NOT THE TIME FOR THE WRECKLESS EXPANSION OF ENTITLEMENT PROGRAMS. IN MY ESTIMATION, THERE NEVER WILL BE SUCH A TIME.

I AM WILLING TO AGREE THAT THE FEDERAL GOVERNMENT MUST PLAY A SUBSTANTIAL ROLE IN THE FORMULATION OF A VIABLE LONG TERM CARE COST SOLUTION. BUT I PROPOSE THAT THERE IS A RESOURCE OUT THERE WHICH HAS BEEN IGNORED FAR TOO OFTEN DURING DELIBERATIONS OVER LONG TERM CARE POLICY: THE PRIVATE SECTOR.

ADMITTEDLY, LEGITIMATE STUDIES HAVE ASSIGNED TO THE PRIVATE SECTOR ONLY A LIMITED LONG TERM HEALTH CARE DOMAIN. BUT THE FACT REMAINS THAT THE HEALTH CARE UNDERWRITING INDUSTRY IS IN AN INCREASINGLY ADVANTAGEOUS POSITION TO HELP FILL THE VOID WHICH CURRENTLY EXISTS ACROSS THE RANGE OF APPROACHES TO LONG TERM CARE COST MANAGEMENT.

I AND MY WAYS AND MEANS HEALTH SUBCOMMITTEE COLLEAGUE BRIAN DONNELLY INTRODUCED SOME TIME AGO A BILL, H.R. 3900, WHICH SEEKS EFFECTIVELY TO APPLY THE BEST OF WHAT BOTH THE FEDERAL GOVERNMENT AND THE PRIVATE SECTOR HAVE TO OFFER.

ESSENTIALLY, MY BILL IS DIVIDED INTO THREE SECTIONS:

THE FIRST SECTION ADJUSTS THE MACHINERY OF OUR CURRENT HEALTH CARE ENTITLEMENT PROGRAM AND PROVIDES FOR MEDICARE COVERAGE OF HOME HEALTH SERVICES AND NURSING HOME CARE COSTS. THIS LIMITED

EXPANSION IS ENTIRELY SELF-FINANING -- IT DEMANDS NO PREMIUMS FROM ELIGIBLE INDIVIDUALS -- AND CALLS FOR BENEFICIARY PARTICIPATION IN THE HANDLING OF LONG TERM CARE COSTS THROUGH A CAREFULLY-STRUCTURED SCHEDULE OF DEDUCTIBLES.

SECTION TWO OF MY BILL ESTABLISHES TAX INCENTIVES DESIGNED TO ENCOURAGE THE WORKING-AGE POPULATION TO LOOK TO THE VARIETY OF PRIVATE MARKET INSURANCE PRODUCTS AND PURCHASE INDEPENDENT LONG TERM CARE INSURANCE PLANS. PROMINENT AMONG THESE INCENTIVES ARE THE TAX-FREE CONVERSIONS OF INDIVIDUAL RETIREMENT ACCOUNTS AND CASH-VALUE-LOADED LIFE INSURANCE POLICIES TO PRIVATE LONG TERM CARE PLAN PREMIUM FUNDS.

FINALLY, MY LEGISLATION MOTIVATES EMPLOYERS TO OFFER LONG TERM HEALTH CARE PLANS TO THEIR EMPLOYEES. SUCH PLANS WOULD BE SUBJECT TO A FEDERAL TAX TREATMENT SIMILAR TO THAT APPLIED TO CURRENT PRIVATE PENSION AND GENERAL RETIREMENT PROGRAMS.

SO IT IS THAT, THROUGH A COMBINATION OF DIRECT GOVERNMENT SUPPORT AND PRIVATE SECTOR STIMULATION, MY BILL WOULD ADDRESS OLDER AMERICA'S MOST PRESSING CONCERNS.

I HAVE PLACED A PREMIUM ON BALANCE AND FAIRNESS, AND I HAVE ABOVE ALL SOUGHT TO PROVIDE THE MEANS BY WHICH AN EVER-GROWING ELDERLY POPULATION CAN AVOID THE FINANCIAL AND EMOTIONAL DEVASTATION OF LONG TERM HEALTH CARE COSTS.

CERTAINLY, THERE REMAIN IMPERFECTIONS IN H.R. 3900. BUT THE BILL'S MAJOR STRENGTH LIES IN ITS CONCEPTUAL RECOGNITION OF THE NECESSITY OF A MARRIAGE BETWEEN FEDERAL ENTITLEMENT AND THE PRIVATE SECTOR.

AND IT IS IN DENYING THIS UNION THAT BILLS SUCH AS SENATOR PEPPER'S H.R. 3436 FALL SHORT OF ACHIEVING A LAST-WORD HEALTH

COSTS SOLUTION. PLEASE UNDERSTAND: WHAT DISTURBS ME IS NOT SO MUCH THE METHOD WHEREBY MR. PEPPER HAS CHOSEN TO FINANCE HIS HOME HEALTH CARE BENEFIT (INDEED, MY OWN BILL MAKES LIMITED ADJUSTMENTS TO THE HOSPITAL INSURANCE PORTION OF THE FICA TAX); RATHER, IT IS THE CONSTRUCTION OF THE BENEFIT ITSELF.

H.R. 3436 WOULD ESTABLISH A MASSIVE NEW HOME HEALTH CARE BENEFITS PROGRAM WHOSE AMBIGUITIES RENDER IT VIRTUALLY UNWORKABLE WHILE IGNORING BOTH NURSING HOME COSTS -- INARGUABLY THE TRUE HEALTH CARE CATASTROPHE IN AMERICA TODAY -- AND THE PRIVATE SECTOR -- A VERY VALUABLE RESOURCE TO A GROWING OLDER POPULATION.

ABOVE ALL, THIS LEGISLATION FURTHERS THE CURRENT TREND OF HEALTH CARE SOCIALIZATION, A PHENOMENON NEVER ENVISIONED, I AM QUITE SURE, BY MEDICARE'S ORIGINAL DESIGNERS.

MISTER CHAIRMAN, I WILL SUBMIT THAT THE AMERICAN INSURANCE INDUSTRY MIGHT WELL BE CONSIDERED AN ENDANGERED SPECIES IN THE VERY NEAR FUTURE IF DEVELOPMENTS ARE PERMITTED TO PROCEED AT THEIR PRESENT PACE.

STILL, PROMISING MEASURES SUCH AS SENATOR MITCHELL'S S. 2305 RECENTLY HAVE BEGUN TO RECEIVE MUCH-DESERVED ATTENTION. IN THE DISTINGUISHED SENATOR'S BILL WE WITNESS THE IMPLICIT RECOGNITION THAT THE FEDERAL GOVERNMENT'S ROLE IS NOT THAT OF OBLIGATORY COMPENSATOR; IT IS, RATHER, THAT OF BENEFICIAL AND TIMELY PROVIDER.

S. 2305 EMPHATICALLY ASSERTS THAT THERE IS AMPLE ROOM HERE FOR BOTH THE GOVERNMENT AND PRIVATE INDUSTRY TO LEND A HELPING HAND TO THE LONG TERM CARE COST VICTIM. AND THE BILL PROMISES TO DELIVER WHERE IT IS MOST NEEDED, BOTH ON THE HOME CARE AND NURSING HOME FRONTS.

I APPLAUD SENATOR MITCHELL'S EFFORTS, AND HOPE THAT CONGRESS CAN LOOK TO HIS EXAMPLE IN FUTURE EFFORTS TO SHAPE SOUND, EQUITABLE, COST-EFFECTIVE HEALTH CARE POLICY.

MISTER CHAIRMAN, THANK YOU ONCE AGAIN FOR THIS OPPORTUNITY. I AM CONFIDENT THAT SINCERE AND RESPONSIBLE CONGRESSIONAL ACTION EVENTUALLY WILL RESULT IN THE END OF THE AMERICAN LONG TERM CARE CRISIS.

STATEMENT OF THE COMMITTEE ON HEALTH
AMERICAN ACADEMY OF ACTUARIES
ROBERT H. DOBSON, CHAIRPERSON

JUNE 17, 1988

The American Academy of Actuaries is a professional association representing actuaries in all areas of actuarial practice. Members of the Committee on Health who prepared this testimony are employed both as consultants and by insurance companies. For purposes of this testimony, however, we speak as professional actuaries and not on behalf of our clients or employers. The Academy and its committees do not advocate public policy positions that are not actuarial in nature. We view our role in the government relations arena as providing information and actuarial analysis to public policy decision makers, so that policy decisions can be made on the basis of informed judgment.

As a professional association, the Academy neither supports nor opposes legislation to provide for the public financing of long-term care. We do, however, believe the cost of providing such benefits has been understated. As the dialogue begins on the delivery and financing of long-term care, we want to provide policymakers with the best information on this complex topic. It is very difficult to make cost projections for long-term care; however, we believe that the training and experience of actuaries provides for a unique understanding of current practices in the financing of health care, and we hope to contribute to the examination of this issue.

I. COST ISSUES

A. Demographic Issues - Increasing Cost as the Population Ages

The chart below outlines the projected increase of the population over age sixty-five.

------Population in Millions*-------

Year	(1) Total All ages	(2) Age 65+	(3) Age 65-74	(4) Age 75-84	(5) Age 85+	% of (2)/(1)
1980	226.5	25.5	15.6	7.7	2.2	11.3%
1990	249.7	31.7	18.0	10.4	3.3	12.7%
2000	268.0	34.9	17.7	12.3	4.9	13.0%
2010	283.2	39.2	20.3	12.3	6.6	13.8%

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*Source is "Aging America - Trends and Projections" 1987-88 Edition.

The U.S. aged population has increased and is projected to increase dramatically from an actual 25.5 million in 1980 to a projected 39.2 million in the year 2010. This is a projected increase of over 50%. However, the number of age eighty-five and over (85+) will triple in the same thirty years, from 2.2 million to 6.6 million. Currently, 13.4% of those aged sixty-five and over (65+) cannot perform at least two or more activities of daily living (ADL). The comparable percentage for those aged 85+ is 36.1%.

Additionally, a conservative estimate is made that a minimum of 5% of those 65+ suffer from dementia, but are able to perform all the ADLs or all but one ADL. Given these projections, the need for, and expenditures on, long-term care (LTC) is likely to increase dramatically in the ensuing years, particularly for the 85+ group.

B. Induced Demand - Entitlement Mentality and Increased Supply - Health Industry Response

Once chronic home care benefits are provided through the public or private sector, the mentality of the consumer will likely be to liberally use these benefits. The independent assessors from the eligibility review organizations may have a very difficult time denying many possible borderline cases regarding the criteria of inability to perform at least two ADLs and as to when respite care is really "necessary." Induced utilization of the nursing care benefit may be less severe, particularly because of the two-year exclusionary period. The insurance industry will likely develop policies to fill this gap in coverage.

Since home health agencies are likely to be the primary providers of the chronic home health care benefit, I believe that these agencies will multiply quickly to satisfy the demands of the possible millions of new beneficiaries. Again, the insurance industry will enhance this movement with policies to fill the gap.

C. Eligibility for Benefits

The provision of home health care benefits (80% payment by Medicare after a $500 per year home care expense) for the aged with chronic illness who cannot perform at least two of the ADL without human assistance, or who have dementia, opens the door for about 5.5 million aged 65+ persons. In addition, a considerable portion of the approximately 4 million (under sixty-five) Social Security disability insurance beneficiaries might be eligible for this benefit. Thus, more than 7 million persons might be eligible, even now for this benefit, for which no cost estimate has been given in S.2305. The only restriction given is that home health care costs cannot exceed 65% of skilled nursing facility (SNF) Medicare nursing home costs. Assuming that an average SNF cost per day is currently $70 to $100, the 65% limitation stipulated would create an average current daily liability of $45 to $65. Currently, approximately 80% of these persons are receiving home care only from a spouse or relative.

A respite care benefit provided in this bill would provide a $1,000 annual benefit ($2,000 of charges at 50% co-payment), for at least the 80% of those persons above who are now getting informal care.

The eligibility requirements for the above benefits may be difficult to assess correctly and consistently, due to the subjectivity of the ADL performance determination, without any homebound or other screening requirement. With a two-year exclusionary period for the nursing home benefit, we cannot foresee large-scale difficulties in making equitable eligibility determinations.

D. Cost Estimates

There are no cost estimates given in this bill. Instead, the claim is made that the program will remain budget neutral. We question that a useful government LTC program can be established that will be budget neutral without imposing an inappropriate burden on the elderly. Adding homemaker and chore services, as well as serving significantly more beneficiaries (see Eligibility for Benefits section) will be very expensive. Removing the homebound and intermittent service requirements will further add to the cost. This will also be a growing cost in the future, not only due to inflation, but also due to the increase in exposure (see Demographic Issues). Changes in demand and supply will also affect cost (see Induced Demand). All of these factors make it difficult to estimate costs.

Based on Congressional Budget Office estimates, the nursing home cost in FY 1993 with a two-year exclusionary period, will approximate $13.2 billion. Our own very rough estimate for the 7 million extra beneficiaries of home health care might range from $22 to $34 billion for the first year and an additional $3 billion for respite care. In claiming budget neutrality, S.2305 would do all this by adding a fixed and income-based premium to the current Medicare Part B premium.

E. National Affordability or Medicare Eligible's Burden

One of the most problematic aspects of this bill is the enormous and spiraling burden placed on Medicare beneficiaries for the privilege of participating in the program. First, all Part B beneficiaries will see increases in their basic premium. However, political reality may not allow this increase to become too extreme. As program costs increase, the only "moving target," the supplemental premium, will impose a significant and unpredictable "tax" burden on those (44% - according to catastrophic bill estimates)* who will have to shoulder the experiences of the whole group.

The combination of the Medicare catastrophic legislation and the Mitchell bill could add up to a significant amount in supplemental premiums in a few years. Some of these individuals may not have enough left over to pay premiums for Medicare supplemental or LTC insurance to fill the gaps. If this bill is enacted, the cost of medical care ($44 to $57 billion extra) will certainly increase as a portion of the GNP from its present 10%-11%, since a large percentage of these costs were previously absorbed by family support. When the tax burden on Medicare eligibles gets too high, who will be handed the tax baton to pay the ever-increasing costs of this LTC program?

II. Policy Decision - Nursing Home Care vs. Home Health Care vs. Family Support

As long as quality of health and personal care is maintained, home health care should be favored over nursing home care. Costs will be less, not only because of the 65% of SNF maximum allowable for home health care, but also because professional nursing/chronic care services might not be required on a daily basis, particularly if family support is available. In fact, the purpose of respite care is to allow some relief to persons providing family support. In essence, however, the bill will encourage substitution of professional home health care for family care.

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*Appropriate only only if S.2305 income-scaled premium is equal to catastrophic Medicare income-scaled premium.

III. Private Sector Initiatives

Some fifty to seventy commercial health insurance carriers, in addition to sixteen Blue Cross and Blue Shield Plans, currently have a long-term care policy on the market. The policies vary in benefit scope and level, but are primarily indemnity in nature. This implies significant cost-sharing and limited insurer liability.

Senator Mitchell's bill will affect many private-sector policies by reducing the benefits they are providing to a "fill" level. However, since there is a $500 deductible on home health care with a 20% co-payment after the deductible, and a two-year exclusionary period on nursing home care with a 30% co-payment, there is considerable room for new private-sector policies to fill these gaps.

IV. Design Issues

One recognized shortcoming of the bill, as well as with virtually all current private-sector policies, is that the insured is still exposed to a significant LTC financial risk. Since this bill has a two-year exclusionary period on nursing home care, a person could become impoverished by that time. Likewise, the 30% co-payment on nursing home care after year two, and the 20% co-payment on home health care, could add up very quickly to greatly increase the individual's expenses. The private market indemnity program usually has an elimination period of twenty to 100 days, a significant co-payment after the elimination period, with a two-to-four year benefit maximum, or an equivalent dollar maximum limitation. The accumulation of co-payments and subsequent full payments by the individual after exceeding the insurer's upper limit of liability also does not protect the individual from a financial catastrophe. Since, however, cost is a major concern, legislation such as this is a good starting point. We believe the public/private approach is certainly worthy of further discussion and development.

V. Conclusion

The purpose of this testimony has been to point out cost issues, policy decisions, and the private sector response relating to this legislation. We hope that as Congress continues further on the development a new Medicare benefit for long-term care it will proceed with caution and deliberation, bearing in mind the concerns we have raised today. We would be happy to meet with the Committee or members of the staff to further discuss these issues.

July 15, 1988

The Honorable George J. Mitchell
Chairman, Subcommittee on Health
Committee on Finance
U.S. Senate
205 Dirksen Senate Office Building
Washington, DC 20510

Subject: Senate Subcommittee on Health hearing of June 17, 1988; response to question from Senator Mitchell.

Dear Senator Mitchell:

On behalf of the Committee on Health of the American Academy of Actuaries, I am pleased to respond to your question regarding the liklehood of cost increases as a result of induced utilization under a program providing long-term care insurance. As we said in our testimony, once long-term care benefits are provided through either the public or private sector, the mentality of the consumer will likely be to liberally use these benefits. We believe that fewer people will do without services they may need now but cannot afford, and families may provide less in the way of uncompensated care. At the same time, the health industry will respond to the demands of possibly millions of new beneficiaries and the availability of additional financing by devoting more resources to providing long-term care services. In short, costs will increase beyond the increased number of beneficiaries and inflation directly as a result of the additional financing.

The attached table illustrates the utilization history of an existing program (Medicare's home health care program) for a population likely to use the benefits that would be provided under S. 2305. We believe the induced utilization effects caused by influences such as those listed in Column 4 account for a substantial proportion of the patterns of use illustrated. An absolute quantification of what proportion of the trend changes are due to induced utilization cannot be precisely made or proved. However, in "real world" casting, strong circumstantial evidence presents itself in characteristic patterns (e.g., the relatively violent utilization swings in a program of this size).

Our concern regarding induced utilization is further supported by data as to the proportion of the over-sixty-five population currently in nursing homes versus the proportion with limitations on activities of daily living. Data from the U.S. Bureau of the Census (Demographic and Socioeconomic Aspects of Aging in the United States) show that 5.1% of the over-sixty-five population are in nursing homes, while an additional 6.9% have limitations on activities of daily living (ADL). An Inquiry magazine article in 1980 cited the total proportion of the over-sixty-five population with major ADL limitations as 17%. Since many of these individuals could seek nursing home care if financial obstacles were reduced, we believe that additional public financing of long-term care could conceivably double or triple the total proportion of the over-sixty-five population in nursing homes.

As we said in our testimony before the subcommittee, we are not suggesting that S.2305 would lead to a greater degree of induced utilization any more than any other public or private financing of long-term care. What we wish to emphasize is that policy makers must be aware that costs will increase because of additional financing and that this must be kept in mind as the issue of long-term care is debated.

We hope these comments serve to clarify our concerns regarding the impact of induced utilization on costs associated with a long-term care insurance program. We would be glad to answer any questions you might have about our comments and to work further with you and your staff in addressing the issue of long-term care for the elderly.

Sincerely,

Robert H. Dobson

Robert H. Dobson
Chairperson, Committee on Health

encl.

In response to Senator Mitchell's inquiry re: induced utilization of professional medical care for the elderly, prompted by:

- long term establishment of an insurance program,
- expanded contractural insurance benefits,
- changes in administratively defined benefits/medical necessity standards.

The long-term history of the Medicare home health care program displays the following:

(1) Calendar Year	(2) Home Health Care Visits Per 1000 Medicare Enrollees*	(3) % Change in (2) From Prior Year	(4) Significant Events Affecting Utilization: Comments
1969	424		Initial coverage "utilization bulge" and aftereffects (including, probably, administrative tightening).
1970	291	(31.4%)	
1971	226	(22.3%)	
1972	241	6.6%	
1973	263	10.0%	Disabled and ESRD beneficiaries eligible for Medicare, 7/1/73.
1974	340	28.3%	
1975	431	26.8%	
1976	520	20.6%	Era of loosening/lax administrative/medical necessity standards, probably.
1977	597	14.8%	
1978	639	7.0%	
1979	717	12.2%	
1980	792	10.5%	
1981	902	13.9%	Elimination of prior hospitalization/SNF requirement and 100 annual) visit maximum - 7/1/81.
1982	1,060	17.5%	
1983	1,252	18.1%	Final regulations issued 4/5/83 to the Omnibus Reconciliation Act of 1981, to be effective 5/5/83. These regulations make Medicare secondary to employer group health plans for rendered to ESRD beneficiaries within months 3 through 12 after ESRD eligibility is established.
1984	1,343	7.3%	
1985	1,324	(1.4%)	Era of tightened administrative standards; e.g., number of skilled nurse home health visits administratively limited to no more than "two to three weeks" for up to five visits per week, barring certification of extenuating medical circumstances.
1986	1,303	(1.6%)	
1987 (estimate)	1,306	0.2%	
1988 (projected)	1,310	0.3%	

* Source: HCFA/Bureau of Data Management & Statistics

STATEMENT OF VAL J. HALAMANDARIS, PRESIDENT

NATIONAL ASSOCIATION FOR HOME CARE

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE,

I AM VAL J. HALAMANDARIS. I SERVE AS PRESIDENT OF THE NATIONAL ASSOCIATION FOR HOME CARE (NAHC). NAHC IS THE LARGEST PROFESSIONAL ORGANIZATION REPRESENTING THE INTERESTS OF HOME HEALTH AGENCIES, HOMEMAKER-HOME HEALTH AIDE ORGANIZATIONS, AND HOSPICES. NAHC IS COMMITTED TO ASSURING THE AVAILABILITY OF HUMANE, COST-EFFECTIVE, HIGH-QUALITY HOME CARE SERVICES TO ALL WHO REQUIRE THEM. WE BELIEVE THAT PEOPLE SHOULD BE ALLOWED TO REMAIN IN THEIR HOMES FOR AS LONG AS POSSIBLE, WITH INSTITUTIONALIZATION AS A LAST RESORT.

WE COMMEND YOU FOR SPONSORING THE MEDICARE LONG TERM CARE ACT OF 1988, S.2305, AND FOR HOLDING THIS HEARING. WHILE THE CATASTROPHIC HEALTH INSURANCE BILLS CURRENTLY IN CONFERENCE PROVIDE A RICHER ACUTE CARE BENEFIT FOR MEDICARE BENEFICIARIES, THEY DO NOT BEGIN TO ADDRESS THE PRINCIPLE CATASTROPHIC COSTS THE ELDERLY FACE-- THE COSTS OF LONG-TERM CARE, WHICH AMOUNT TO 80 PERCENT OF ALL SPENDING FOR CATASTROPHIC ILLNESSES. S. 2305 IS AN IMPORTANT VEHICLE FOR GENERATING SERIOUS DISCUSSION ON HOW TO DEAL WITH THIS CRITICAL ISSUE.

QUITE SIMPLY, THE PROBLEM IS THAT MOST PEOPLE ARE NOT ABLE TO PROTECT THEMSELVES AGAINST THE TREMENDOUS COSTS OF LONG-TERM CARE. OLDER PEOPLE WHO ARE UNFORTUNATE ENOUGH TO SUFFER FROM LONG-TERM ILLNESS ARE FORCED ALL TOO OFTEN TO CONSUME WHAT SAVINGS THEY MAY HAVE AND THEN TURN TO PUBLIC ASSISTANCE. THESE PEOPLE OFTEN MUST MOVE TO A NURSING HOME TO RECEIVE THE CARE THEY NEED BECAUSE MEDICAID COVERAGE IS GENERALLY LIMITED TO NURSING HOME CARE.

SOME PEOPLE WHO NEED LONG-TERM CARE SIMPLY GO WITHOUT IT. THE U.S. GENERAL ACCOUNTING OFFICE (GAO) IN A JANUARY 1987 REPORT

NOTED THAT 3.2 MILLION ELDERLY PEOPLE NEED REGULAR HOME NURSING OR OTHER ASSISTANCE TO REMAIN IN THEIR OWN HOMES. WHILE 1.9 MILLION OF THOSE PERSONS WERE RECEIVING SOME CARE (MOSTLY THROUGH RELATIVES), 1.1 MILLION AMERICANS WERE GOING WITHOUT THE CARE THEY NEEDED. MANY OF THOSE HAD NO FAMILY AND NO MEANS TO PAY FOR HOME CARE SERVICES.

AS SERIOUS AS THE THE LONG-TERM CARE PROBLEM IS TODAY, IT WILL GET WORSE. AMERICA IS GROWING OLDER AND MORE PEOPLE ARE GOING TO REQUIRE LONG-TERM CARE SERVICES IN THE YEARS AHEAD. BETWEEN 1988 AND 2040, THE NUMBER OF PERSONS NEEDING LONG-TERM CARE WILL TRIPLE.

BASIC APPROACH

S.2305 TAKES A GIANT STRIDE TOWARD THE DEVELOPMENT OF A REALISTIC AND EFFECTIVE NATIONAL LONG-TERM CARE POLICY. BY SPREADING THE BURDEN OF LONG-TERM CARE COSTS BEYOND THOSE WHO WHO ARE AT RISK, THE BILL WOULD MAKE THE COSTS OF LONG-TERM ILLNESS AFFORDABLE. AND THE AVAILABILITY OF THE MEDICARE PROTECTION WILL MEAN THAT THE ELDERLY WILL NO LONGER HAVE TO USE UP THEIR SAVINGS OR TURN TO WELFARE TO OBTAIN THE LONG-TERM CARE THEY NEED.

THE BILL WOULD REDRESS THE BIAS THAT NOW EXISTS IN FAVOR OF INSTITUTIONALIZING PERSONS WITH LONG-TERM DISABILITIES. THIS BIAS EXISTS BECAUSE FINANCING IS PRESENTLY MUCH MORE WIDELY AVAILABLE FOR NURSING HOME CARE THAN FOR HOME CARE, ESPECIALLY UNDER MEDICAID, DESPITE THE CLEAR PREFERENCE OF AMERICANS TO REMAIN AT HOME AS LONG AS POSSIBLE.

ACCORDING TO A REPORT BY THE HOUSE SELECT COMMITTEE ON AGING, RESEARCH INDICATES THAT THE BULK OF LONG-TERM CARE PROVIDED IN THE U.S. IS PROVIDED IN THE COMMUNITY. ONLY ONE IN FIVE ELDERLY PERSONS WHO HAVE LONG-TERM CARE NEEDS IS LIVING IN A NURSING HOME. NAHC STRONGLY FAVORS THE PROVISIONS OF THE BILL WHICH PROVIDE A CHOICE OF COMMUNITY CARE ALTERNATIVES. BY MAKING RESPITE CARE AND DAY CARE AVAILABLE IN ADDITION TO HOME CARE, THE

BILL RECOGNIZES THAT MUCH OF THE LONG-TERM CARE THAT IS PROVIDED IN THE COMMUNITY IS FURNISHED BY UNPAID FAMILY MEMBERS, FRIENDS, AND NEIGHBORS. NEARLY THREE-QUARTERS OF THE NON-INSTITUTIONALIZED DISABLED ELDERLY PERSONS RELY SOLELY ON FREE CARE FROM FAMILY AND FRIENDS WHILE ONLY 5 PERCENT RECEIVE ALL OF THEIR CARE FROM PAID SOURCES.

HOWEVER, WE ARE ALSO CONCERNED, AS I KNOW THE SUBCOMMITTEE IS, THAT THESE CONTROLS BE EXERCISED IN A MANNER THAT WILL ASSURE THAT BENEFICIARIES WILL RECEIVE ALL NEEDED SERVICES TO WHICH THEY ARE ENTITLED. WE WOULD APPRECIATE HAVING THE OPPORTUNITY TO WORK WITH YOUR STAFF TO SEE WHAT SAFEGUARDS MIGHT BE ADOPTED TO ASSURE THAT THE INTERESTS OF THE PATIENTS ARE FULLY PROTECTED. WE BELIEVE THAT PAST EXPERIENCE WITH THE MEDICARE HOME HEALTH PROGRAM SUPPORTS OUR VIEW THAT HOME HEALTH AGENCIES COULD PLAY A USEFUL PATIENT ADVOCACY ROLE IN THE PROPOSED PROGRAM.

FEE-FOR-SERVICE REIMBURSEMENT

THE LEGISLATION ALSO PROVIDES FOR REIMBURSEMENT BASED ON A FEE SCHEDULE. SUCH A SYSTEM WOULD HAVE MANY ADVANTAGES OVER THE COST REIMBURSEMENT SYSTEM THAT MEDICARE NOW USES FOR FOR HOME HEALTH AGENCIES AND MOST SKILLED NURSING FACILITIES. HOWEVER, THE OVERRIDING CONSIDERATION IS THAT THE PROPOSED FEES SHOULD BE REASONABLY RELATED TO THE SERVICES THEY COVER. IF THE FEES FOR SOME TYPES OF SERVICES OR FOR SOME CLASSES OF PATIENTS ARE PROFITABLE WHILE OTHERS LOSE MONEY, PATIENT CARE COULD SUFFER. ECONOMIC INCENTIVES WOULD BE CREATED THAT WOULD DISADVANTAGE THE PATIENTS THAT NEED THE UNDERPAID SERVICES AND THREATEN THE FINANCIAL STABILITY OF AGENCIES THAT WOULD CHOOSE NEVERTHELESS TO PROVIDE THOSE SERVICES.

THE ELDERLY MEDICARE BENEFICIARIES WHO WOULD QUALIFY FOR THE LONG-TERM CARE BENEFITS WOULD TEND TO BE THE OLDEST AND POOREST OF THE ELDERLY. THEY WOULD NOT ONLY HAVE THE MOST TROUBLE PAYING THE DEDUCTIBLE AND COINSURANCE AMOUNTS BUT ALSO BE LEAST LIKELY TO HAVE BEEN ABLE TO AFFORD PRIVATE MEDIGAP INSURANCE THAT WOULD COVER THE DEDUCTIBLE AND COINSURANCE.

ABOUT 9% OF THE ELDERLY ARE ELIGIBLE FOR MEDICAID. THIS SUBCOMMITTEE MAY WISH TO CONSIDER AMENDING THE FEDERAL MEDICAID STATUTE TO PERMIT OR REQUIRE STATES TO PAY ANY HOME CARE DEDUCTIBLE AND COPAYMENT AMOUNTS FOR INDIVIDUALS WHO ARE OTHERWISE ELIGIBLE UNDER THEIR STATE'S PLAN. SUCH AN AMENDMENT WOULD HELP AVOID SITUATIONS WHERE AN INDIVIDUAL QUALIFIES FOR MEDICAID BUT CAN ONLY RECEIVE ASSISTANCE IF HE MOVES TO A NURSING HOME. BUT EVEN A MEDICAID PROGRAM THAT HAS BEEN AMENDED TO PAY THE LONG-TERM COPAYMENT AMOUNTS WILL BE OF LIMITED HELP: NEARLY A THIRD OF THE ELDERLY WHOSE INCOMES FALL BELOW THE FEDERAL POVERTY LEVEL ARE NOT ELIGIBLE FOR MEDICAID.

CASE MANAGEMENT

WE ARE NOT YET PREPARED TO MAKE SPECIFIC RECOMMENDATIONS CONCERNING THE PROVISIONS OF THE BILL THAT DEAL WITH CASE MANAGEMENT AND DETERMINATIONS OF ELIGIBILITY. WE RECOGNIZE THE NEED FOR CONTROLS THAT WILL HELP PROTECT THE PROGRAM AGAINST UNWARRANTED UTILIZATION AND COSTS.

HOWEVER, THIS SO-CALLED "FREE" CARE CAN BE VERY COSTLY TO THOSE WHO ARE INVOLVED. IN ADDITION TO THE LIMITATIONS THAT ARE PLACED ON THE CAREGIVER'S PERSONAL LIFE AND OPPORTUNITIES FOR GAINFUL EMPLOYMENT, THERE ARE DEBILITATING EMOTIONAL AND PHYSICAL DEMANDS THAT ARE FELT BY THE ENTIRE FAMILY. THE AVAILABILITY OF RESPITE CARE AND DAY CARE SHOULD HELP EASE THESE BURDENS AND MAXIMIZE THE CARE OF THE ELDERLY BY FAMILY AND FRIENDS. AVAILABLE DATA INDICATES THAT FAMILIES TEND TO PURCHASE SERVICES ONLY WHEN THE RESPONSIBILITY OF CARE BECOMES TOO GREAT FOR THEM TO HANDLE OR WHEN THEY BECOME EXHAUSTED.

WE DO, HOWEVER, HAVE SOME CONCERNS RELATING TO THE HOME CARE PROVISIONS IN THE BILL AND WOULD LIKE TO WORK WITH THIS COMMITTEE TO FURTHER REFINE THESE PROVISIONS.

COPAYMENTS AND DEDUCTIBLES

THE BILL REQUIRES AN ANNUAL $500 DEDUCTIBLE FOR HOME CARE SERVICES AND A 20 PERCENT COPAYMENT BY BENEFICIARIES. WE

RECOGNIZE THE DIFFICULTY OF FASHIONING A PROPOSAL WITHOUT COPAYMENT GIVEN THE LIMITED FUNDING THAT IS AVAILABLE. HOWEVER, WE ARE COMPELLED TO NOTE THAT COST SHARING WOULD BE BURDENSOME FOR MANY OF THE MEDICARE BENEFICIARIES WHO WOULD QUALIFY FOR THE LONG-TERM CARE BENEFITS. SOME 12% OF THE ELDERLY HAVE INCOMES BELOW THE POVERTY LEVEL WHILE OVER 28% PERCENT HAVE INCOMES BELOW 125% OF THE POVERTY LEVEL.

THE UNDER-65 DISABLED

FINALLY, WE URGE THAT THE PROPOSED COVERAGE FOR HOME CARE SERVICES BE EXTENDED TO DISABLED ADULTS AND CHRONICALLY ILL CHILDREN. AS WE TESTIFIED BEFORE YOUR COMMITTEE YESTERDAY, TECHNOLOGY NOW EXISTS WHICH ALLOWS CHRONICALLY ILL CHILDREN TO BE CARED FOR IN THEIR HOMES. HOWEVER, FUNDING MECHANISMS HAVE NOT EMERGED TO PAY THE COSTS OF THIS NEW TECHNOLOGY.

WE URGE THAT HOME CARE COVERAGE BE MADE AVAILABLE TO CHRONICALLY ILL AND TECHNOLOGY-DEPENDENT DISABLED PERSONS OF ALL AGES. LONG TERM CARE COSTS ARE NOT SIMPLY A PROBLEM FOR THE ELDERLY.

PUBLIC SUPPORT

MR. CHAIRMAN, THE GREAT MAJORITY OF AMERICANS AGREE THAT THE TIME HAS COME TO PROTECT OUR CITIZENS AGAINST THE COSTS OF LONG-TERM CARE. IN A PUBLIC OPINION POLL THAT LOUIS HARRIS CONDUCTED IN FEBRUARY, OVER 80 OF THE RESPONDENTS SAID THAT THEY WOULD NOT BE ABLE TO AFFORD LONG-TERM CARE. AN EQUAL PERCENTAGE FAVORED THE FEDERAL GOVERNMENT PROVIDING A PROGRAM OF LONG-TERM CARE IN THE HOME TO THE CHRONICALLY ILL AND DISABLED ELDERLY, ADULTS AND CHILDREN.

IN TESTIFYING ON H.R. 3436, THE LONG TERM CARE HOME CARE LEGISLATION INTRODUCED BY CONGRESSMAN CLAUDE PEPPER AND CONGRESSMAN EDWARD ROYBAL BEFORE THE HOUSE COMMITTEE ON AGING LAST MONTH, MR. HARRIS REPORTED THAT HE HAD RARELY SEEN SUCH UNANIMITY OF PUBLIC OPINION. SUPPORT FOR HOME-CARE LEGISLATION WAS BOTH BROAD AND DEEP AMONG ALL AGE GROUPS, FROM ALL PARTS OF THE NATION, AND AMONG BOTH LIBERALS AND CONSERVATIVES OF BOTH PARTIES. MR. CHAIRMAN, MAY I ASK THAT THE RESULTS OF THIS POLL BE MADE PART OF THE RECORD?

IN CONCLUSION, WE THANK THIS COMMITTEE FOR ITS CONSIDERATION OF THE CRITICAL ISSUE AND WE LOOK FORWARD TO WORKING WITH YOU IN REFINING THE HOME CARE PORTION OF S.2305.

John Heinz

OPENING STATEMENT OF SENATOR JOHN HEINZ

HEARING ON S.2305, LONG TERM CARE ASSISTANCE ACT OF 1988

MR. CHAIRMAN, THIS HEARING OF THE SENATE FINANCE COMMITTEE REPRESENTS A CRITICAL JUNCTURE IN OUR EFFORTS TO PROTECT OLDER AMERICANS AND THEIR FAMILIES FROM THE CRIPPLING COSTS OF LONG TERM CARE. AT LONG LAST, WE ARE CONSIDERING LEGISLATION WHICH WILL RESPOND TO MILLIONS OF PERSONAL CRISES CAUSED BY THE HIGH COST OF LONG TERM CARE.

THIS LEGISLATION IS DESERVING OF WIDESPREAD SUPPORT. YOU HAVE PUT TOGETHER THE FIRST COMPREHENSIVE BILL TO FINANCE LONG TERM CARE, A BILL ON WHICH I AM PROUD TO BE AN ORIGINAL COSPONSOR. S.2305 IS COMPREHENSIVE IN THAT IT PROVIDES CRITICALLY NEEDED COVERAGE OF BOTH CHRONIC HOME CARE AND NURSING HOME CARE, AND BECAUSE IT RELIES UPON A COMBINATION OF PRIVATE AND PUBLIC FINANCING.

FOUR YEARS AGO I WAS PRIVILEGED TO CHAIR A HEARING OF THE SPECIAL COMMITTEE ON AGING FOCUSING ON THE NEED FOR LONG TERM CARE INSURANCE. AS I POINTED OUT THEN, WHEN IT COMES TO INSURANCE, AMERICA IS A LAND OF PLENTY. OUR NATION'S MIDDLE CLASS CAN INSURE THEIR CARS AGAINST THEFT OR DAMAGE, THEIR HOUSES AGAINST FLOOD, FIRE, AND EARTHQUAKES, THEIR CHILDREN AGAINST THE COST OF COLLEGE AND BRACES, AND THEIR FAMILIES AGAINST THE FINANCIAL RISK OF AN EARLY DEATH.

BUT WHEN IT COMES TO INSURING AGAINST THE SINGLE GREATEST THREAT TO THEIR LIFE SAVINGS AND EMOTIONAL RESERVES -- THE COST OF LONG TERM CARE -- AMERICANS HAVE LITTLE PROTECTION. I NOTED AT THAT

TIME THAT IN MANY WAYS IT IS AS IF WE ARE ALL WEARING BULLETPROOF VESTS -- WITH HOLES OVER OUR HEARTS. WE ARE MISSING PROTECTION WHERE WE NEED IT MOST.

THAT WAS FOUR YEARS AGO. TODAY, MANY PEOPLE QUESTION WHETHER THIS LEGISLATION IS STILL NEEDED. SINCE THEN, THEY POINT OUT, PRIVATE INSURANCE FOR LONG TERM CARE COSTS HAS BEEN DEVELOPED AND SOLD TO OVER 400,000 AMERICANS. EACH YEAR, THE QUALITY OF COVERAGE OFFERED UNDER THESE POLICIES HAS IMPROVED. IN 1984, FOR EXAMPLE, MOST POLICIES COVERED NO CHRONIC NURSING HOME CARE. TODAY, MANY POLICIES OFFER NOT ONLY CHRONIC NURSING HOME COVERAGE, BUT ALSO PAY FOR CHRONIC CARE IN THE HOME, AS WELL.

BUT THIS LEGISLATION IS NEEDED BECAUSE, UNFORTUNATELY, AS THE QUALITY OF THESE POLICIES HAS RISEN, SO HAS THEIR COST. ONE LONG TERM CARE POLICY RECENTLY APPROVED FOR MARKETING IN MY HOME STATE OF PENNSYLVANIA OFFERS TRULY COMPREHENSIVE CHRONIC CARE SERVICES. THIS INSUROR ESTIMATES THAT HALF OF THE TARGETED MARKET -- ELDERLY PERSONS HOLDING MEDIGAP POLICIES -- ARE SIMPLY PRICED OUT OF THE MARKET. THE BROOKINGS INSTITUTION INDEPENDENTLY REACHED A SIMILAR CONCLUSION IN ITS RECENTLY PUBLISHED STUDY, FOR WHICH I WAS PRIVILEGED TO SERVE ON AN ADVISORY PANEL.

MOREOVER, MR. CHAIRMAN, MY CONVERSATIONS WITH PRIVATE INSURORS INDICATE THAT FUTURE IMPROVEMENTS IN PRIVATE INSURANCE, SUCH AS BENEFITS ADJUSTED FOR THE ERODING EFFECTS OF INFLATION, WILL REQUIRE PREMIUM INCREASES OF AS MUCH AS 30%. MOREOVER, NO PRIVATE INSUROR HAS YET BEEN ABLE TO AFFORD TO OFFER A POLICY TO PERSONS WHO ARE ALREADY DISABLED OR SERIOUSLY ILL.

THESE PROBLEMS OF COST AND ACCESS ARE PERHAPS THE MOST COMPELLING ARGUMENTS FOR A STRONG PUBLIC ROLE IN INSURING AGAINST THE COST OF LONG TERM CARE.

YOUR BILL, MR. CHAIRMAN, WILL PROVIDE PROTECTION DESPERATELY NEEDED BY PEOPLE SUCH AS MRS. ELLA THOMAS OF PHILADELPHIA, PENNSYLVANIA. MR. AND MRS. THOMAS RETIRED SEVERAL YEARS AGO AND WERE CARING FOR THEIR MENTALLY RETARDED SON, WHO COULD NOT FUNCTION ON HIS OWN. THEY FELT CERTAIN THAT THEIR MEDICARE AND BLUE CROSS POLICY WOULD COVER THEIR HEALTH CARE NEEDS, UNTIL MRS. THOMAS SUFFERED A STROKE. SHE SPENT 6 MONTHS IN REHABILITATION BEFORE SHE WAS DISCHARGED HOME TO THE CARE OF HER 78 YEAR OLD HUSBAND. AFTER ONE MONTH OF CARING FOR HIS WIFE AND THEIR SON, MR. THOMAS ALSO SUFFERED A STROKE, AND SUBSEQUENTLY REQUIRED 24 HOUR ASSISTANCE. THIS FAMILY SPENT THEIR ENTIRE SAVINGS AND MOST OF THEIR INCOME OVER A 3 YEAR PERIOD, TOTALLING SOME $66,000. MEDICARE AND BLUE CROS PAID NONE OF THESE COSTS. THE FAMILY COULD NOT QUALIFY FOR MEDICAID WITHOUT PLACING MR. THOMAS IN A NURSING HOME -- AND AS ANYONE IN PHILADELPHIA CAN TELL YOU, MEDICAID ELIGIBLE PERSONS HAVE A DIFFICULT TIME FINDING A NURSING HOME BED IN THAT CITY.

IN CONSIDERATION OF THE VERY HIGH PRICE TAG OF A PUBLIC PROGRAM, HOWEVER, CONGRESS SHOULD SEEK TO ENSURE THAT COMPREHENSIVE AND AFFORDABLE PRIVATE LONG TERM CARE INSURANCE COVERAGE IS WIDELY AVAILABLE TO THE ELDERLY AND DISABLED. THE LONG TERM CARE ASSISTANCE ACT OF 1988 ACCOMPLISHES THIS GOAL BY CREATING TAX INCENTIVES FOR PRIVATE LONG TERM CARE INSURANCE, INCLUDING INCENTIVES FOR WORKPLACE-BASED INSURANCE. IN ADDITION, BY EXTENDING MEDICARE COVERAGE TO NURSING HOME CARE, THIS BILL SHOULD PICK UP SOME 30% OF THESE COSTS NOW BORNE BY PRIVATE INSURORS, ENABLING THEM TO LOWER PREMIUMS. THUS, THIS LEGISLATION NOT ONLY LOOKS TO THE PUBLIC SECTOR, IT ENCOURAGES THE PRIVATE SECTOR TO JUMP IN AS WELL. IT IS A BILL THAT TOUCHES NEATLY ON ALL FACETS OF THE SOLUTION.

OUR WORK IS FAR FROM DONE, HOWEVER. CONGRESS STILL MUST ADDRESS THE CRITICAL PROBLEM OF THE INADEQUACY OF THE MEDICAID PROGRAM. FOR EXAMPLE, IN TWENTY STATES TODAY IT IS POSSIBLE TO SPEND ALL OF ONE'S INCOME FOR LONG TERM CARE AND REMAIN INELIGIBLE FOR MEDICAID PAYMENTS. I WILL BE WORKING WITH SENATOR MITCHELL AND THE OTHER COSPONSORS TO CORRECT THIS fault {SEVERE DEFECT} IN THE MEDICAID FOUNDATION UPON WHICH THIS LEGISLATION IS BUILT.

IN CLOSING, I WOULD LIKE TO CONGRATULATE YOU, MR. CHAIRMAN, AND YOUR STAFF, FOR YOUR SUCCESS IN CRAFTING LEGISLATION THAT IS SURE TO SERVE AS THE BASIS FOR ALL LONG TERM CARE LEGISLATION IN THIS, AND THE NEXT, CONGRESS.

STATEMENT OF THE HONORABLE CLAUDE PEPPER
CHAIRMAN, SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE
HOUSE SELECT COMMITTEE ON AGING
BEFORE THE SUBCOMMITTEE ON HEALTH
SENATE FINANCE COMMITTEE

MR. CHAIRMAN AND DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE. I GREATLY APPRECIATE THIS OPPORTUNITY TO APPEAR BEFORE YOU TO DISCUSS WHAT IS ARGUABLY THE MOST IMPORTANT DOMESTIC ISSUE FACING OUR NATION TODAY, LONG-TERM CARE.

CHAIRMAN MITCHELL, I WANT TO SPECIALLY COMMEND YOU FOR YOUR ACTIVE INVOLVEMENT WITH THIS ISSUE. IN YOUR SERVICE WITH THE SENATE, YOU HAVE BEEN ON THE FRONT LINES IN TRYING TO RELIEVE ALL AGES OF THE PRESSURES THAT COME FROM TRYING TO MEET THE COSTS OF NEEDED HEALTH CARE. I SALUTE YOU AND LOOK FORWARD TO WORKING CLOSELY WITH YOU AND THE MEMBERS OF THIS COMMITTEE IN THE COMING WEEKS AND MONTHS SO THAT WE CAN PROVIDE THE AMERICAN PEOPLE WITH WHAT THEY WANT AND DESPARATELY NEED: LEGISLATION TO HELP THEM WITH THE DEVASTATING COSTS OF LONG-TERM CARE.

MY INTEREST IN LONG-TERM CARE AND SPECIFICALLY HOME CARE DATES BACK TO MY DAYS IN THE SENATE. IN 1943, AFTER IT WAS FOUND THAT 4 MILLION YOUNG MEN WERE REJECTED FROM THE DRAFT BECAUSE THEY WERE NOT PHYSICALLY OR MENTALLY FIT, THE SENATE ESTABLISHED AND I CHAIRED A SPECIAL COMMITTEE ON WARTIME HEALTH AND EDUCATION. AFTER THREE YEARS OF HEARINGS, WE RECOMMENDED, AMONG OTHER THINGS, THAT ANY "HEALTH INSURANCE PROGRAM SHOULD INCLUDE HOME NURSING IN ADDITION TO NURSING CARE IN THE HOSPITAL, CLINIC OR OTHER INSTITUTION." SO, 40 YEARS AGO WE CONCLUDED THAT HOME CARE WAS SORELY NEEDED BY CHRONICALLY ILL AND DISABLED AMERICANS OF ALL AGES.

SOME PROGRESS HAS BEEN MADE SINCE THAT TIME. MEDICARE AND MEDICAID WERE ENACTED INTO LAW IN 1965, PROVIDING COVERAGE ON A VERY LIMITED BASIS. IN 1981, CONGRESSMAN HENRY WAXMAN AND I AUTHORED LEGISLATION WHICH CREATED THE SO-CALLED "2176" MEDICAID WAIVER PROGRAM ALLOWING FOR SOME EXPANSION OF HOME CARE TODAY FOR IMPOVERISHED ELDERLY WHO WOULD OTHERWISE BE IN A NURSING HOME. HOWEVER, TODAY, ONLY APPROXIMATELY 3 PERCENT OF MEDICAID AND MEDICARE EXPENDITURES GO FOR HOME CARE. MUCH MORE NEEDS TO BE DONE.

IN AN ATTEMPT TO ADDRESS THIS CRITICAL NATIONAL NEED, AS MOST OF YOU KNOW, LAST YEAR I INTRODUCED WITH CONGRESSMAN EDWARD ROYBAL, CHAIRMAN OF THE HOUSE AGING COMMITTEE, H.R. 3436, THE MEDICARE LONG-TERM HOME CARE CATASTROPHIC PROTECTION ACT. THIS BILL IS NOW SCHEDULED FOR A HOUSE VOTE JUNE 8TH.

BRIEFLY, H.R. 3436 WOULD PROVIDE NEEDED HOME CARE SERVICES TO CHRONICALLY ILL AMERICANS OF ALL AGES AND WOULD BE PAID FOR BY REQUIRING THE ROUGHLY 5 PERCENT OF AMERICANS EARNING MORE THAN $45,000 A YEAR TO JOIN OTHER WORKERS IN PAYING THE 1.45 MEDICARE PAYROLL TAX ON THEIR FULL INCOME. HIGHLIGHTS REGARDING H.R. 3436 INCLUDE:

- H.R. 3436 ENJOYS WIDESPREAD SUPPORT IN AND OUT OF CONGRESS. IT IS COSPONSORED BY 160 MEMBERS OF THE HOUSE AND MORE THAN 70 OTHER MEMBERS HAVE COMMITTED TO VOTING FOR IT. THE BILL ALSO HAS THE STRONG SUPPORT OF SOME 130 DIVERSE NATIONAL ORGANIZATIONS. LOU HARRIS, IN A RECENT NATIONAL POLL, FOUND THAT OVER 80 PERCENT OF AMERICANS OF ALL AGES, INCOMES, AND POLITICAL LEANINGS FAVOR A FEDERAL PROGRAM LIKE H.R. 3436. IN ADDITION, THE HARRIS POLL FOUND THAT OVER 70 PERCENT OF AMERICANS FAVORED THE TAX PROVISIONS OF H.R. 3436. THIS SUPPORT INCLUDED 73 PERCENT OF AMERICANS EARNING OVER $50,000, 78 PERCENT OF BUSINESS EXECUTIVES AND 61 PERCENT OF BUSINESS OWNERS.

- AMERICANS GREATLY PREFER HOME CARE. AMERICANS, YOUNG AND OLD ALIKE, OVERWHELMINGLY PREFER HOME CARE OVER NURSING HOME CARE. LOU HARRIS FOUND THAT 78 PERCENT OF AMERICANS WOULD PREFER TO RECEIVE LONG-TERM CARE IN THEIR OWN HOMES RATHER THAN IN A NURSING HOME.

- H.R. 3436 HAS NUMEROUS COST CONTROLS AND CANNOT RESULT IN A DEFICIT. THE BILL, BY ITS DESIGN, IS COMPLETELY SELF-FINANCING. THE OFFICIAL CONGRESSIONAL BUDGET OFFICE ESTIMATE ON H.R. 3436 SHOWS THAT DURING THE FIRST FIVE YEAR COSTS WILL TOTAL $29.3 BILLION WHILE REVENUES WILL TOTAL $34.9 BILLION AND CONFIRMED THAT IN NO YEAR WILL COSTS EXCEED REVENUES. THE BILL NOW INCLUDES LANGUAGE ASSURING ITS SELF-FINANCING WHICH GOES BEYOND EVEN THAT DEMANDED BY THE ADMINISTRATION ON THE DRUG BENEFIT CONTAINED IN THE CATASTROPHIC CARE LEGISLATION.

  H.R. 3436 EMPLOYS THE FOLLOWING COST CONTROLS: 1) PAYMENTS FOR LONG-TERM HOME CARE FOR AN INDIVIDUAL IN A MONTH COULD NOT EXCEED 62 PERCENT OF WHAT IT WOULD HAVE COST TO KEEP THAT INDIVIDUAL IN A NURSING HOME. 2) BENEFITS ARE PROVIDED ONLY ON A CASE-MANAGED BASIS AS PRESCRIBED BY AN INDEPENDENT LOCAL GOVERNMENT AGENCY. 3) A SYSTEM OF UTILIZATION REVIEW IS ESTABLISHED. 4) THE SECRETARY IS REQUIRED TO DEVELOP A PROSPECTIVE PAYMENT SYSTEM FOR LONG-TERM HOME CARE.

- PRIVATE INSURANCE IS NOT ADEQUATE PROTECTION AGAINST THE COSTS OF LONG-TERM CARE. AT THE PRESENT TIME, PRIVATE LONG-TERM CARE INSURANCE IS NOT A GOOD BUY. STUDIES BY THE GENERAL ACCOUNTING OFFICE, THE BROOKINGS INSTITUTION, CONSUMER REPORTS AND OTHERS HAVE DEMONSTRATED THE INADEQUACY OF RELYING ON PRIVATE INSURANCE TO PROVIDE MEANINGFUL AND AFFORDABLE LONG-TERM CARE PROTECTION NOW OR IN THE FUTURE.

FOR THESE AND OTHER REASONS, I AM CONFIDENT THAT THE HOUSE WILL OVERWHELMINGLY PASS H.R. 3436 ON JUNE 8, AND SEND IT ON TO THIS DISTINGUISHED BODY FOR CONSIDERATION.

I AM DELIGHTED THAT YOU AND A NUMBER OF YOUR DISTINGUISHED COLLEAGUES HAVE INTRODUCED LEGISLATION, S.2305, WHICH BUILDS IN LARGE PART UPON H.R. 3436 AND ITS SENATE COMPANION, S.1616, INTRODUCED BY THE GREAT SENATOR FROM ILLIOIS, PAUL SIMON. I KNOW THAT WE CAN WORK TOGETHER TO GAIN PASSAGE OF LONG-TERM CARE LEGISLATION THIS YEAR. AS WE WORK TOGETHER TO ACHIEVE THIS IMPORTANT MUTUAL GOAL, I HOPE THAT YOU WILL GIVE CONSIDERATION TO SEVERAL IMPORTANT OBSERVATIONS I HAVE REGARDING YOUR BILL.

FIRST, IT IS IMPERATIVE THAT LONG-TERM HOME CARE COVERAGE BE MADE AVAIABLE TO CHRONICALLY ILL AND DISABLED CHILDREN AS CALLED FOR IN H.R. 3436. THE NEEDS OF CHILDREN AND YOUNG FAMILIES IN THIS AREA ARE GREAT AND MOST DESERVING OF EQAUL CONSIDERATION. SECOND, WE NEED TO WORK TO LIMIT FURTHER INCREASES IN MEDICARE PREMIUMS AND COST SHARING. FOR MANY ELDERLY, THIS LOAD IS ALREADY TOO GREAT. THIRD, AS WE MOVE INTO NURSING HOME COVERAGE, OUR GOAL MUST BE TO PROTECT PEOPLE OF ALL INCOMES FROM FINANCIAL RUIN AND THE TREMENDOUS EMBARASSMENT OF ENDING LONG AND PROUD LIVES ON WELFARE ROLLS. WE CAN FINANCE SUCH BENEFITS ADEQUATELY WITHOUT PLACING EXCESSIVE BURDENS ON WORKERS OR EMPLOYERS.

THANK YOU SO MUCH FOR HAVING ME HERE THIS MORNING AT THIS HISTORIC HEARING. GOOD THINGS ARE IN THE MAKING. AND THE AMERICAN PEOPLE ARE FIRMLY ON OUR SIDE.

# # # # # # # # #

JOAN QUINN, PRESIDENT

CONNECTICUT COMMUNITY CARE, INC.

GOOD MORNING, MY NAME IS JOAN QUINN. I AM THE PRESIDENT OF A STATEWIDE, INDEPENDENT, NONPROFIT, LONG-TERM CARE MANAGEMENT AGENCY CALLED CONNECTICUT COMMUNITY CARE, INC. THE AGENCY HAS BEEN IN OPERATION SINCE 1974, INITIALLY UNDER A 2176 MEDICARE WAIVER DEMONSTRATION CALLED TRIAGE, INC. PRESENTLY, WE CARE FOR APPROXIMATELY 5000 OLDER AND DISABLED CONNECTICUT ADULTS EACH MONTH. WE HAVE BOTH PUBLIC AND PRIVATE CONTRACTS.

I APPLAUD SENATOR MITCHELL FOR HIS EFFORTS IN INTRODUCING LEGISLATION TO PROVIDE LONG-TERM CARE TO THE NATION'S OLDER CITIZENS. THROUGH MY 14 YEARS OF EXPERIENCE IN THE DELIVERY OF LONG-TERM CARE, CASE MANAGEMENT AS A COMPONENT IS KEY IN THE DELIVERY OF APPROPRIATE, AFFORDABLE LONG-TERM CARE SERVICES. I WILL LIMIT MY REMARKS, THEREFORE, TO THE CASE MANAGEMENT AREA IN SENATOR MITCHELL'S LEGISLATION.

THERE IS NO DOUBT THAT THE AREA OF LONG-TERM CARE IS OF CONCERN TO THE ELDERLY AND THEIR FAMILIES. THIS CONCERN IS EVIDENT EVERY DAY IN THE COMMUNITY AND THE WORKPLACE. THE LACK OF A NATIONAL POLICY HAS RESULTED IN DIFFICULT ACCESS TO THE MYRIAD OF COMMUNITY SERVICE PROVIDERS, FUNDED BY DIFFERENT STATE AND FEDERAL AGENCIES WITH DIFFERENT ELIGIBILITY RULES, QUALIFICATIONS, AND DELIVERED SERVICES. THE AVAILABILITY OF SERVICE IS SPOTTY AROUND THE COUNTRY AND OFTEN PEOPLE, IF NOT TOTAL SELF PAY, CANNOT AFFORD IT. CASE MANAGEMENT IS A SUCCESSFUL METHOD TO ADDRESS THIS FRAGMENTED SERVICE AND REIMBURSEMENT SYSTEM. THERE ARE FIVE MAJOR POINTS THAT I WOULD LIKE TO MAKE REGARDING CASE MANAGEMENT SERVICES.

- CASE MANAGEMENT, WHICH INCLUDES ASSESSMENT OF THE INDIVIDUAL AND FAMILIES' NEEDS, CARE PLANNING AND MONITORING OVER TIME OF THE CLIENT AND THE SERVICE

PROVIDER, IS A VALUABLE SERVICE IN AND BY ITSELF (SEE ATTACHED FAMILY SUPPORT LETTERS). IT MUST BE PROVIDED BY PROFESSIONALS. THERE IS AN INHERENT ADVOCACY, COST BENEFIT, AND EDUCATIONAL COMPONENT OF THE SERVICE.

- THE INDEPENDENCE OF THE CASE MANAGEMENT FUNCTION FROM ONGOING SERVICE PROVISION IS ESSENTIAL. THE ABILITY TO USE MULTIPLE SERVICE PROVIDERS AND TYPES OF SERVICE WITHOUT HAVING A VESTED INTEREST RESULTS IN COST SAVINGS. THE CASE MANAGER CAN SELECT QUALITY SERVICE IN THE RIGHT AMOUNTS, DELIVERED AT THE RIGHT TIME FOR THE CLIENT, AND AT THE LOWEST POSSIBLE COST.

- THE CASE MANAGEMENT AGENCY SHOULD HAVE THE ABILITY TO REIMBURSE FOR THE SERVICES ORDERED FOR THE CLIENT. THE REIMBURSEMENT AUTHORITY FOR SERVICES ORDERED ALLOWS FOR BETTER CONTROL OF BOTH TYPE AND UTILIZATION OF SERVICE.

- CREATING AN INFRASTRUCTURE FOR UNIFORM QUALITY LONG-TERM CARE CASE MANAGEMENT SERVICES IS BEGINNING. THERE ARE TEN CASE MANAGEMENT AGENCIES NATIONALLY WHO ARE CURRENTLY WORKING TO DEVELOP THIS NATIONAL INFRASTRUCTURE. SOME FUNDING FOR THE INITIAL TRAINING ACTIVITIES OF THIS GROUP WOULD BE HELPFUL. FOR EXAMPLE, CONNECTICUT COMMUNITY CARE, INC. HAS CONDUCTED A NATIONAL CASE MANAGEMENT TRAINING INSTITUTE FOR THE PAST THREE YEARS WITH PARTICIPANTS FROM AROUND THE COUNTRY, INCLUDING HAWAII AND ALASKA IN ATTENDANCE. THE TRAINING INSTITUTE WAS INITIALLY SUBSIDIZED THROUGH A GRANT BY THE TRAVELERS INSURANCE COMPANIES. ALL PARTICIPANTS PAY FOR THE SEMINAR; HOWEVER, I FEEL MANY PROFESSIONALS ARE EXCLUDED FROM PARTICIPATING FOR FINANCIAL REASONS.

ESTABLISHED CASE MANAGEMENT AGENCIES HAVE PRIVATE CASE MANAGEMENT SERVICE CONTRACTS IN PLACE AND ARE NEGOTIATING NEW ONES. IT IS ANTICIPATED THAT AN INFRASTRUCTURE OF QUALITY, UNIFORM CASE MANAGEMENT AGENCIES WILL BE AVAILABLE WITHIN THE NEXT TWO YEARS. IT IS THE BELIEF OF THE TEN AGENCIES THAT A PUBLIC-PRIVATE RESPONSE TO LONG-TERM CARE NEEDS IS ESSENTIAL BECAUSE OF THE SIGNIFICANT NUMBER OF AGING OLDER ADULTS WHO MAY NEED SERVICES.

DOES THE CASE MANAGEMENT AGENCY SAVE MONEY FOR THE PAYOR? ANY LONG TERM CARE SERVICES PRESENTLY DELIVERED ARE PAID FOR WITH PUBLIC DOLLARS AND THE CONSUMER OF SERVICES (EITHER THROUGH THE FAMILY OR THE OLDER PERSON HIM/HERSELF). PRIVATE INSURANCE COMPANIES ARE DEVELOPING LONG-TERM CARE INSURANCE POLICIES, BUT THIS HAS BEEN A MORE RECENT ACTIVITY. ONGOING LONG-TERM CARE POLICY DEVELOPMENT BY INSURERS IS RESULTING IN BETTER COVERAGE POLICIES.

CONNECTICUT COMMUNITY CARE, INC. HAS CONTRACTED WITH THE CONNECTICUT STATE DEPARTMENT ON AGING TO PROVIDE CASE MANAGEMENT AND COMMUNITY-BASED SERVICES TO OLDER RESIDENTS WITH FUNCTIONAL AND/OR COGNITIVE DISABILITY. WE ALSO HAVE A RISK-BASED CONTRACT WITH THE STATE DEPARTMENT OF INCOME MAINTENANCE (TITLE XIX) TO PROVIDE SERVICES UNDER THE 1115 MEDICAID WAIVER PROGRAM. UNDER THIS SPECIFIC PROGRAM, PEOPLE 65 YEARS OLD AND OLDER MUST MAKE APPLICATION TO A NURSING HOME AND MEET ALL LEVEL OF CARE CRITERIA FOR THE NURSING HOME. THEY, THEN CAN AVAIL THEMSELVES, THROUGH THE CASE MANAGEMENT FUNCTION, OF EXPANDED COMMUNITY HEALTH AND SOCIAL SUPPORT SERVICES. OUR MOST RECENT STATISTICS SHOW THAT THE AVERAGE STATEWIDE MONTHLY COST FOR SERVICES INCLUDING CASE MANAGEMENT SERVICES IS $838.64. NURSING HOME

MONTHLY COSTS IN CONNECTICUT ARE AN AVERAGE OF $2224.37 PER MONTH. THERE WILL BE ONGOING DEBATE ABOUT COST SAVINGS OF COMMUNITY-BASED CARE. THE QUALITY OF LIFE FOR THE ELDERLY AND THEIR FAMILIES IS NOT QUESTIONED OR OPEN FOR DISCUSSION.

WHETHER PUBLIC OR PRIVATE MONIES FINANCE LONG-TERM CARE, THERE IS A GREAT NEED TO CREATE VIABLE ALTERNATIVES FOR SERVICE DELIVERY, LOCATION OF CARE, AND FINANCIAL PROTECTION FOR OLDER PEOPLE AGAINST THE CATASTROPHIC EFFECTS SECONDARY TO LONG-TERM CARE NEED. PARTNERSHIPS BETWEEN THE CLIENT, THE FAMILY CAREGIVER, AND THE PUBLIC/PRIVATE SECTOR ARE NECESSARY.

I WOULD BE HAPPY TO ASSIST YOU AND YOUR STAFF AS YOU CONTINUE TO WORK ON THIS IMPORTANT ISSUE.

SUMMARY:

CASE MANAGEMENT IS A VITAL COMPONENT OF ANY LONG-TERM CARE PROGRAM FOR OLDER AND DISABLED INDIVIDUALS. IT IS A SUCCESSFUL METHOD TO ADDRESS THE CURRENT FRAGMENTED SERVICE AND REIMBURSEMENT SYSTEM.

CASE MANAGEMENT IS A VALUABLE SERVICE IN ITSELF. THERE IS AN INHERENT ADVOCACY, COST BENEFIT AND EDUCATIONAL COMPONENT OF THE SERVICE.

THE INDEPENDENCE OF THE CASE MANAGEMENT FUNCTION FROM ONGOING SERVICE PROVISION IS ESSENTIAL.

THE CASE MANAGEMENT AGENCY SHOULD HAVE THE ABILITY TO REIMBURSE FOR SERVICES ORDERED FOR THE CLIENT.

CREATING AN INFRASTRUCTURE FOR UNIFORM QUALITY LONG-TERM CARE CASE MANAGEMENT IS BEGINNING. SOME FUNDING FOR TRAINING OF PROFESSIONALS IS NEEDED TO ASSURE QUALITY CASE MANAGEMENT SERVICE. THE INFRASTRUCTURE CAN BE AVAILABLE WITHIN THE NEXT TWO YEARS.

THE COST OF CASE MANAGEMENT SERVICES WILL SAVE MONEY FOR THE PAYOR WHEN THE CASE MANAGERS ARE SUFFICIENTLY TRAINED AND ORIENTED TO THE FUNCTION.

THERE IS GREAT NEED FOR CREATIVE VIABLE SERVICE DELIVERY ALTERNATIVES, A DIVERSITY OF LOCATIONS FOR CARE, AND FINANCIAL PROTECTION FOR OLDER PEOPLE AGAINST THE CATASTROPHIC EFFECTS OF LONG TERM CARE SERVICE NEEDS. PARTNERSHIPS BETWEEN THE CLIENT, THE FAMILY CAREGIVER, AND THE PUBLIC/PRIVATE SECTOR IS ESSENTIAL TO A SUCCESSFUL PLAN.

MAR 2 - 1982

Wethersfield, Connecticut
March 18, 1982

Letters To The Editor
The Hartford Courant
285 Broad Street
Hartford, Connecticut 06115

Dear Mr. Murphy:

This is in response to Marc Gunther's March 5 article concerning the debate over the effectiveness and need for the assessment and monitoring services provided by Connecticut Community Care, Inc for its patients in the health and home care programs. Senator Nancy L. Johnson of New Britain has introduced a bill (I believe it is Senate Bill 97) which would close CCCI's offices and institute direct service by the local home-health agencies.

My mother is a client of CCCI and has always received excellent and careful attention by the agency. I was present at the screening interview described, which the article states "probes such sensitive areas as religion, emotions, sexuality and daily habits as well as health." The interview was conducted in a purely conversational manner and she was told she needn't reply to anything objectionable to her. We did not consider the questions "intrusiv or that we were being "cross-examined." It was obvious the questions posed wer meant to afford the interviewer with insight as to the general well-being, mental and physical health of the patient. The interview provided the means to assess the patient's real needs which is one of the agency's prime function. With the information obtained, I felt the agency was fully equipped to provide the services required, being fully cognizant of mother's entire situation. CCCI made its assessment and instituted service within a very few days.

Our experience with the many local servicing agencies has often left much to be desired in terms of quality and reliability of service provided. In such instances, CCCI would locate another suitable agency. We found that the servicing agencies do not provide any kind of follow-up and the employees, once assigned, are left to their own devices reporting their own time worked. There were instances of "short days" put in of which the agency had no knowledg and for which it billed in full. When absences occurred, often no substitute was provided. The agencies leave it to the patients to report problems and often they are fearful of "reporting" anyone. This is the area where CCCI's "watchdog" capacity is so valuable. CCCI maintains contact with their clients, picking up any difficulties encountered. It also provides regular follow-up visits to update and reassess current needs. They have been most accomodating in their efforts on our behalf.

The costs incurred by CCCI are well spent. The screening and monitoring process allows it to maintain a profile of its elderly clients whose needs it must represent and satisfy. I see another function of CCCI and that is one as advocate for and caretaker of its elderly clients' best interests. Direct assignment of the elderly to the various health agencies would be stressful, requiring them to personally deal with interrupted or inadequate service, absences and sundry other problems. Should the elderly be burdened with agencies that are not well run, wasteful practices and billing errors (which we have encountered)?

Without this program, mother would be unable to live in her own home because of her health. Like many of that generation, she is fiercely independent and wants and needs to be in her own home. She is very happy to be living alone and is doing quite well with the assistance provided by this program. The alternatives, a nursing home or living with one of her children, are not entirely palatable to a woman of her genre.

This program should continue as it is and funding for CCCI should be increased so that others like my mother can avail themselves of all its benefits.

Very truly yours,

Mary

cc: Naomi Otterness
Mary Martin
Co-Chairmen, Human Services Committee

Gardner Wright
Marcella Fahey
Co-Chairmen, Appropriations Committee

Represantative Robert G. Gilligan

Senator William E. Curry, Jr.

Middletown
Connecticut 06450

May 8, 1984

Connecticut Community Care, Inc.
Route 6 - P. O. Box 459
Brooklyn, Connecticut 06234

Dear :

I would like to thank you for the prompt attention I received from CCC Inc.

The nurse's aide came the following week after your visit and I really enjoyed the scrubbing she gave me. She also came the following week on Wednesday to help with my bath etc., and then on Thursday May 3, she came again to see that I got to and from the doctor's office safely.

I have completed all the required documents and application for a subsidized apartment with either .
They are managed by Carrabetta Management, Inc., Box 240, Meriden, Connecticut 06450. I am now awaiting their reply. If you should wish to write to them, please address correspondence to a very nice young lady named "Lisa." She, like yourself, has been very helpful.

I also received an application from the Local Housing Authority but have not replied thereto. I had my application in with them before the building was completed and I was still employed at The Press. But, I heard absolutely nothing from them until about 3½ or 4 years later when I was settled here and could afford to stay.

I hope, if you are ever in this area again, you will do me the honor of a visit. It would surely make my day. Since my financial problems erupted last year, everyone has been very kind and helpful and I hope, some day, to repay all of you who have helped me so much, not just for material reasons but for the friendliness and pleasure your visit and those of others have helped raise my spirits.

Thank you personally for your time and the pleasurable manner in which you handled my situation and would you please convey to all the people at CCC Inc. my kindest thanks and warmest regards.

God Bless!

Sincerely,

Mrs. Marguerite

APR 2 8 1982

Manchester, Connecticut, 06040
April 20, 1982

Connecticut Community Care, Inc.
1 Congress Street
Hartford, Connecticut
06114

Dear :

has been working with my mother, , for over a year and has recently made arrangements for her to enter Silver Lane Pavilion as she has to move from the boarding home where she has been living with .

Since the move became necessary has had to deal with a very complex and difficult situation which would try the patience of a saint! To just hit the highlights -- would not tell my mother directly that she wanted her to move, although she had told both and the visiting nurse. My mother's resistance was extremely high and she refused to believe the rest of us that it was indeed true. In addition, immediately family did not know until a few days ago that this was desire -- so they were as confused as I was as to what the reality of the situation was. In the meantime I have been feeling very guilty as I felt I should offer to have her with us, although this was not a realistic arrangement.

During this period walked "the second mile" many times over with all of us. In fact, by this time I would think this case would have begun to feel like the Boston Marathon to her!

I feel she has done an outstanding job of working all of us through a morass of non-communication, indirectness, fear, guilt and resistance in a patient, yet firm and caring way.

Sincerely,

Joyce

Southbury, Connecticut
06488
December 16th, 1985

c/o Connecticut Community Care Inc.,
527 Wolcott Street
Waterbury, Connecticut 06705

Dear ,

I am writing this note to express my deep graditude to you for all your assistance in trying to help my 91½ year old mother.. and I might add in trying to help me to help my mother. I feel your interest, compassion and concern are above and beyond your call of duties.

In a time when so many are always busy and hurried I want you to know , I appreciate all you've done and just knowing I can call you for assistance is very comforting and deeply appreciated.

My very best wishes to you and yours for good health, peace and very happy holidays.

Sincerely yours,

Dorothy

Dorothy

cc - Director /Connecticut
Community Care INC.

July 18, 1985

Dear

I just wanted to take the time to say thank you for all your help on the telephone. It is very difficult trying to deal with an elderly relative who needs help when you don't know where to go or what to ask! Thank you for your patience, understanding and pleasant cooperation. I now feel as if I am off to a good start and that my father-in-law will begin to receive the services he so desperately needs.

You were a pleasure!
(and I'm sure still are!!!)
Thanks so much.

Sincerely
Annet

3 Oct 84

Dear

It would be presumptuous of me to say 'you'll never know...', because you know very well what your support and generosity meant to me and my mother.

Her death was serene. Her beloved sister was able to make it up from Virginia in time to sit with her in her last hours. There were no tubes, heroic efforts, or harried doctors & nurses limiting our number. So my gift to my mother was a gift to myself as well.

Now that it's over I look like a hero – you're the hero, I couldn't have done it without you. I wish more people had sent money instead of Masses and flowers – My dear mother would have liked, as I would, to see the money spent on us, returned to the system. I've never seen a well that couldn't run dry, and I'd never feel good about myself again if you had to say no to someone in such desperate need.

Thanks for everything

Christine

P.S. Patrick was born 26 Sept 84 – wonderfully fat & healthy!

8

McLean Fund

Trustees:
William K. Cole, *Chairman*
Daniel P. Brown, Jr
Deborah B. Eddy
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Robert S. Martin, M.D
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Frank E. Walton
John D. Britton, *Trustee Emeritus*
David R. Bailey, *Executive Director*

McLean Fund and McLean Home
75 Great Pond Road
Simsbury, CT 06070
(203) 658-2254

McLean Home Village
4 Sarah Lane
Simsbury, CT 06070
(203) 651-8660

November 8, 1986

Case Manager
Connecticut Community Care, Inc.
1-9 Congress Street
Hartford, Connecticut 06106

Dear :

A special note of thanks for your timely intervention in the care of my grandmother, . Your ability to quickly respond to the family situation when she lived in Broad Brook and your continued support when she moved to West Hartford was a great help to myself and my family in providing for her care at home as she so strongly desired. Although she only needed minimal outside assistance until her last few days, it was this assistance that allowed her to die in her own home.

Again, thank you for your support. I will continue to speak out on behalf of Connecticut Community Care, Inc. and the strength of the program.

Cordially,

Nancy
Associate Director
Director of Community Services

NER/srb

cc Ms. Joan Quinn

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Executive Director

July 16, 1984

Connecticut Community
Care Inc.
1-9 Congress Street
Hartford, CT 06106

Dear .,

A very special thank you for the assistance you provided through C.C.C.I. for

Your very quick response for the initial assessment in the spring not only was greatly appreciated, but it provided a source of support to the family. Although, additional direct care service was not needed at that time, both and her daughters knew where to turn when and if the traditional health care service could not meet their needs.

On the day before expired, you again provided immediate response to the families' request for assistance. At the time of the request, there had been someone with constantly for the past week and a half, and additional relief was critical to allow to die at home without acute hospitalization. It was ironic, considering all of the time spent with by the hospice home health aide (2 hours a day), her daughters and myself that expired the next afternoon during the time that the person you sent was providing care.

It is through organizations such as C.C.C.I. that appropriate care can be coordinated in a timely, cost effective manner. The service provided by C.C.C.I. needs to be available to supplement traditional health care providers. We were indeed fortunate that you were available to respond to our call for assistance.

Thank You,

Cordially,

Nancy E. Ryan, R.N., M.S.
Vice President, Nursing Services

NER:sg

cc: Molly Gavin, Regional Director
Joan Quinn, President

Jay Rockefeller

STATEMENT FOR FINANCE SUBCOMMITTEE ON HEALTH ON THE LONG-TERM CARE ASSISTANCE ACT OF 1988

SENATOR JOHN D. ROCKEFELLER IV

May 27, 1988

Mr. Chairman, thank you for holding this hearing on the "Long-Term Care Assistance Act of 1988." Your leadership on this very important issue is truly admirable. In March, when I signed on as an original co-sponsor of your bill, I was proud and honored to join you in the effort to tackle the challenge of long-term care head-on.

The American people clearly want Congress to act on the need for long-term care coverage. While it is obvious that Medicare, Medicaid, other government programs, and private health insurance must be expanded to cover long-term care, it is by no means a simple or inexpensive goal to accomplish.

Thanks to the leadership of Senator Mitchell, Senator Bentsen, and the rest of our committee, we are close to enacting catastrophic legislation that will primarily improve Medicare's coverage of *acute* care for our elderly. While we all wish we could "rest" from our labors, I think we knew that when we made the commitment to focus on "catastrophic health care," we would *have* to act on long-term care. It clearly is time to respond to the enormous problems that befall elderly when they suddenly encounter the need for ongoing, long-term care at home, in a nursing home, or some other setting. Care in these cases may not require the same sophisticated technology or medical services as hospital care. It is as vital, however, to our elderly and their ability to continue living, functioning, and remaining as comfortable as possible.

Making long-term care *affordable* and *available* is the challenge ahead. We must answer questions on who should pay, how much will it cost, and how to divide responsibilities among government, the private sector, and beneficiaries. More specifically, we have to make it so that elderly no longer will be forced to impoverish themselves when they or their spouses need long-term health care and assistance.

I believe the Long-Term Care Assistance Act serves as a historic first step towards solving this problem and filling in the gaps. I should also note that I'm pleased to be a co-sponsor of Senator Durenberger's Rural Long-Term Care Demonstration Act, which deals with concerns about the *availability* of long-term care services. This legislation will test various ways of providing care in rural areas and finding out what works best.

I look forward to hearing and learning from the witnesses today. I am pleased to be a part of this effort and am deeply committed to playing an active role in producing answers and action as soon as possible. At the same time, whatever we do, we want to to do it right. Let's make sure we face up to the costs involved when trying to provide long-term coverage, and let's truly mobilize public, private, and individual resources to accomplish this crucial objective.

John D. Rockefeller IV

STATEMENT FOR FINANCE SUBCOMMITTEE HEARING ON THE LONG-TERM CARE ASSISTANCE ACT OF 1988

SENATOR JOHN D. ROCKEFELLER IV
JUNE 17, 1988

Thank you, Mr. Chairman, for holding this second hearing on your long-term care bill. I share your obvious committment to this issue and concern for elderly Americans.

As you acknowledge - and I and other cosponsors have emphasized since we joined you in introducing this bill last April, this bill is a natural starting point for a major national dialogue on the best ways to finance long-term care. These hearings are helping us shape the "Long-Term Care Assistance Act" into a better bill. It also informs the public that we are earnest in our efforts to learn more about the problem so that we can enact a bill that meets the long-term care needs of elderly Americans.

I am struck by the diversity of the witnesses here this morning. Their presence here today attests to the great need this country has for some type of mechanism to pay for long-term care. They will provide us with a very healthy mix of viewpoints and I welcome the opportunity to hear their thoughts.

Personally, I tend to favor the mix of public and private sector roles - as outlined in your bill, Mr. Chairman. No one here needs to be reminded about the budget constraints we are forced to legislate under, on a daily basis - the federal deficit is one very strong argument against a new entitlement program for long-term care. But we must recognize the responsibility to ensure that the elderly are not forced into poverty when faced with a physical or mental disability that requires them to seek assistance with activities basic to life - whether in a nursing home or at home.

Mr. Chairman, two weeks ago at a Seniors Town Meeting I held in West Virginia, I heard some very compelling reasons for long-term care coverage. Many elderly expressed relief that the catastrophic bill was so close to enactment, but some were surprised that Medicare still would not cover most nursing home care and that home-health care would still be subject to strict eligibility criteria. I promised them I would continue my work in this vitally important area.

I am proud to be a member of this subcommittee as we work on this task. The decisions we will be making will directly impact the lives of many elderly, especially the lives of some very fragile elderly. So we must take great care that the policies we develop are well thought-out and finely crafted. I look to this impressive gathering of experts to provide us with the guidance and advice we need to carry out this important mission.

CARING FOR THE DISABLED ELDERLY: AN ASSESSMENT OF S.2305*

Alice M. Rivlin and Joshua M. Wiener
Senior Fellows
The Brookings Institution
1775 Massachusetts Avenue, N.W.
Washington, D.C. 20036

Mr. Chairman, we are pleased that the Subcommittee is turning its attention to the difficult issue of financing long-term care for the disabled elderly. We are happy to assist in your consideration of S.2305.

At present the United States does not have, either in the private or the public sectors, satisfactory mechanisms for helping people anticipate and pay for long-term care. The disabled elderly and their families find, often to their surprise, that the costs of long-term care are not covered to any significant extent either by private insurance or by Medicare. They must rely on their own resources or, when these have been exhausted, turn to welfare. We share your view that before the aging of the population puts additional stress on this inadequate system, the Congress should carefully consider alternative ways of financing long-term care and what role the federal government might play in them.

We have just completed a three year study, published by the Brookings Institution in May, called CARING FOR THE DISABLED ELDERLY: WHO WILL PAY?. In the study we:

- assessed the current status of and future demand for long-term care for the disabled elderly;
- evaluated the costs and effects of a wide variety of public and private sector options for paying for long-term care in the future; and,
- suggested some directions for reform.

We are pleased to make the study available to the Subcommittee. Our remarks today will draw on some of the findings of the study that are relevant to the evaluation of S.2305.

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* These opinions are those of the authors and should not be attributed to other staff members, officers, or Trustees of the Brookings Institution.

General Principles of Long-Term Care Financing

We strongly support the general approach to long-term care financing embodied in S.2035, epecially in two important respects. First, we share the view that long-term care expenses should be recognized as a normal risk of growing old. Only a minority of the elderly need long-term care, but for those who must pay for nursing home or extended home care the cost can be far beyond the resources of the average family. These costs should not fall mainly on those unlucky enough to need long-term care, but should be spread over a broader group through public or private insurance.

Second, we believe that solving the problem of financing long-term care will require major efforts by both the public and private sectors. Some contend that the private sector can become the dominant form of long-term care financing. Our analysis suggests that this is unlikely. Even with fairly generous assumptions about who would participate and the willingness of insurers to offer policies, private sector approaches are unlikely to be affordable by a majority of the elderly, to finance more than a modest proportion of total nursing home expenditures, or to have more than a small impact on Medicaid expenditures and the number of people who spend down to Medicaid financial eligibility.

At the other end of the political spectrum, there are those who argue that we should have a very comprehensive public long-term care insurance program with no appreciable role for the private sector. In an environment of large budget deficits and of concern that public costs would be too high, this approach lacks political credibility.

S.2305 reflects a new view which we share: neither public nor private sectors can be expected to carry the full burden of paying for long-term care. We need to increase the roles of both public and private insurance.

Will Private Insurance Expand To Fill The Proposed Deductible Period?

A key element of S.2305 is a two-year elimination period before the public program begins to pay for nursing home benefits. On average, this amounts to a $44,000 deductible, and in some areas of the country it could be $66,000 or more. Thus, the universal availability and aggressive marketing of inexpensive private long-term care insurance to cover the elimination period is crucial to this approach. If affordable private insurance is not widely available, many people will continue to impoverish themselves during the elimination period, much as they do under the current system.

The reason for choosing such a long elimination period is to moderate the size of the incremental taxes necessary to pay for the program. From the prospective of potential nursing home patients, however, this is a risky strategy. Currently only two percent of the elderly have any private long-term care insurance. The crucial question about S.2305, therefore, is whether a large majority of the elderly would buy the insurance necessary to cover the two-year elimination period.

The bill reflects the hope that reducing the time period for which an individual would need private insurance coverage to two years would make such insurance more affordable. Clearly, policies that cover only two years of nursing home care will be less expensive than polices that cover six years of nursing home care. Assuming that all elderly who had at least $10,000 in nonhousing assets and who could afford insurance at 5 percent of their income bought one of the currently available two-year private insurance policies, then, by 2018, we estimate that perhaps 70 percent of the elderly might have coverage. Given that 72 percent of the elderly currently have some Medicare supplemental insurance coverage, it is unlikely that private long-term care insurance will exceed this level of market penetration.

There are, however, some important caveats to this estimate of affordability. First, the policy we simulated costs $473 if initially purchased at ages 65-69, but the cost increases to $1,256 if initially purchased at ages 75-79. At ages 65-69, the premium for this policy is roughly equal to what people currently spend for Medicare supplemental insurance policies. Thus, under this approach, the elderly would have to double what they spend on health insurance.

Moreover, the additional premiums that the elderly will pay for the recently passed catastrophic health care bill will add to their health insurance expenses--an increase expected to be offset only somewhat by reductions in Medicare supplementary insurance premiums.

The second caveat to our insurance affordability estimate is that the the policy we modeled has major limitations that should be eliminated in order to provide adequate financial protection. In the simulated policy, only persons who have been in hospitals are eligible for nursing home coverage and the indemnity payment levels do not increase with inflation. Removing the restrictions will add substantially to the premiums. The Social Security Administration actuaries estimate that a two-year nursing home insurance policy, with a 90 day elimination period but without the other restrictions, would cost significantly more than the insurance policy we modeled--$647 if initially purchased at age 65 and increasing to $1,517 if initially purchased at age 80.

There is also the supply-side question of whether long-term care policies will be available. More and more insurance companies are offering policies and S.2305 should make it easier for them to do so. By clearly defining a gap not covered by the public program, the marketing costs of private insurance should be reduced. Moreover, with the public sector covering the long nursing home stays, the financial risks to insurers are reduced. Nonetheless, insurance companies are likely to remain cautious about entering the market because the risks of financial losses remain significant.

Future financial liabilities of companies remain uncertain because of the potential for moral hazard, adverse selection and misestimating the benefit costs. Insurers are worried about moral hazard--that nursing home use will increase beyond that estimated. Most long-term care is provided informally by families and, even among the severely disabled, more than half are not in nursing homes. They also fear adverse selection--the disproportionate purchase of insurance by those who know they will use long-term care services. Adverse selection pushes use rates up beyond what was assumed in setting premiums, forcing premiums up, causing peoples with a low risk of using services to drop the policies, which further forces premiums up in a vicious circle.

Finally, because long-term care is needed primarily by the very elderly, a long time is likely to elapse between the time of policy purchase and its use. An insurance policy bought at age 65 is not likely to be used until age 85. Over a twenty year period, there is great uncertainty about mortality and disability rates, use of services, and inflation. Something as simple as the proportion of policyholders who are women can substantially affect the amount of benefits paid. An insurance company may not know for twenty years if the policy it initially sold to 65 year olds was priced properly and by then it is too late to change premiums.

To address some of the demand and supply issues, the following policy initiatives should also be considered:

-- Liberalizing Medicaid financial eligibility so that the required level of impoverishment is not so extreme for those who have no choice but to depend on it. This initiative should include increasing the personal needs allowance and the level of protected assets. Such changes would explicitly recognize that some people will never be able to purchase private insurance.

-- Reducing the elimination period from two years to one year. This could reduce private insurance premiums by 40-45 percent. One possible way to pay for this change would be to impose higher copayment levels on people with very long lengths of stay.

-- Subsidizing purchase of insurance by lower and moderate income elderly. Admittedly, this could be administratively cumbersome and may have the stigma of a means test to some elderly.

-- Establishing a federally-sponsored insurance policy to cover the elimination period. Completely self-financed by premiums paid by the elderly, this would ensure that policies would be available to cover the deductible. Problems of adverse selection, however, could be severe.

-- Establishing reinsurance or "stop loss" programs for insurers to encourage them to offer policies.

-- Changing the tax code to make it more advantageous for employers to help pay for long-term care insurance.

What Are The Goals Of Public Long-Term Care Insurance?

From the perspective of the elderly, there are two major goals of public and private long-term care insurance against which proposals such as S.2305 need to be evaluated. The first goal is to prevent the elderly from having to use up all of their life savings simply because they ended up in a nursing home or needing extensive home care. This goal is most important to the middle class and above who have significant assets to protect. Asset protection is obviously less important to people who have little in the way of savings.

The separate but related goal is to prevent elderly people who have been financially independent all of their lives from having to depend on welfare in the form of Medicaid. People with substantial amounts of assets may deplete their savings paying for their nursing home care but may avoid becoming Medicaid eligible. The goal of avoiding welfare dependency is most relevant to the middle class and below who have relatively small amounts of assets to protect. Indeed, according to data from the Survey of Income and Program Participation, approximately 25 percent of single people aged 75 and over (who have the highest risk of using nursing home care) had no liquid assets in 1984 and 70 percent had less than $10,000 in nonhousing assets. Because of the high costs of nursing home care and their minimal savings, the middle class and below often become Medicaid eligible at admission to a nursing home or soon thereafter. Preliminary analysis of the 1985 National Nursing Home Survey suggests that over 70 percent of Medicaid nursing home patients are Medicaid eligible at admission to the nursing home.

Public long-term care insurance strategies that provide protection against catastrophic costs by covering only very long nursing home stays do well with respect to the first goal of protecting assets. The middle class and above are most likely to be able to afford the private long-term care insurance that will protect them against the costs of the elimination period. S.2305 recognizes that the middle class and above will be the major beneficiaries of this strategy and rightly makes them pay for the bulk of the program costs.

Catastrophic approaches, however, do less well by the second goal of preventing the elderly from ending up on Medicaid because the middle class and below are less likely to be able to afford the deductible of the public program. They are also less likely to obtain the necessary private insurance to keep them off Medicaid. The challenge to advocates of catastrophic strategies is to make Medicaid financial eligibility standards less onerous and to help the less well off pay for private insurance.

Conclusion

In sum, we have three basic observations about S.2305. First, the bill properly recognizes that the solution to long-term care financing will require both the private sector and the public sectors to play stronger roles than they do now. Second, it is an open question whether private insurance will be able to expand widely enough to provide the overwhelming majority of elderly with the financial protection necessary to cover a long elimination period. And, finally, policy debate about long-term care financing should recognize that protection of assets and preventing people from becoming welfare patients are related but not identical goals.

Changing the Benefit Structure

Dr. Wiener. One way to find the money to reduce the initial exclusionary period is to change the cost sharing for the social insurance program from 30 to perhaps 40 percent. By covering less of the total cost of nursing home stays, money could be freed up to reduce the exclusionary period. The very real risk is that some people would be unable to pay the increased cost sharing and would end up on Medicaid, defeating the purpose of the program.

An alternative approach to finding money to reduce the exclusionary period would be to limit the coverage of the new public program to nursing home stays lasting two to five years. While less than 10 percent of all nursing home admissions are for more than five years, the part of the stay that exceeds five years represents a disproportionate part of total nursing home expenditures and could be used to help offset the increased costs of the shorter exclusionary period. The obvious difficulty with this strategy is that individuals with extremely long lengths of stay would not be financially protected. Time did not permit me to develop cost estimates of whether this change would be adequate to pay for the costs of the reduced exclusionary period, but this is an issue that we will be investigating in coming months.

Subsidizing the Purchase of Insurance

Dr. Wiener. One way to increase the number of elderly with private insurance would be to subsidize the purchase of insurance by lower and moderate income elderly. This could be done either by establishing a refundable tax credit or by issuing vouchers to targeted groups. Both of these approaches could introduce certain "welfare" elements into the Medicare program and could be administratively complex. In both cases, the subsidy could be related to income.

A refundable tax credit would be the easiest to administer, but faces two critical problems. First, 60 percent of the elderly (and virtually all of the elderly one would want to provide the tax credit) do not currently file federal income tax forms. Thus, they would have to file solely for the purpose of obtaining the refundable tax credit. Second, lower and moderate income elderly may have difficulty coming up with the cash to meet the monthly, quarterly, or annual insurance payments, even if the tax credit reimburses them after the fact.

The second approach would have individuals apply for vouchers at local Social Security or State welfare offices. Individuals would have to fill out an application form where they divulged information about their income and possibly their assets. Individuals meeting the predetermined standard would obtain a voucher that could be used to help purchase private long-term care insurance. Disadvantages of this approach are that it would be complicated to administer and might have the stigma of a means test.

Although time did not permit me to develop a comprehensive cost estimate, I did develop a "ball park" estimate. Assuming a 60 percent participation rate, a $500 subsidy for elderly with family income below $5,000, a $400 subsidy for elderly with family income between $5,000 and $8,999, and a $200 subsidy for elderly with family income between $9,000 and $14,999, I estimate that total costs of the subsidy to be approximately $3.5 billion in 1984. Net costs would be somewhat lower because of Medicaid savings. We will be further investigating this approach in the coming months.

Statement of

Dallas L. Salisbury,
Robert B. Friedland, Ph.D.,
and
Deborah J. Chollet, Ph.D.

Introduction: the Long-Term Care Insurance Gap

Among the general population, recognition that neither Medicare nor most private insurance plans cover long-term care has come slowly. Retirees and workers have only begun to understand their exposure to the risk of needing costly community or institutional long-term care, as an increasing number have faced the desperation of caring for a parent, spouse or child needing chronic (and often increasing) assistance for personal care. Currently, an estimated 13 million people, or 5 percent of the population, require such care. Since few people have recognized the likelihood of needing long-term care, most do not plan to save sufficiently to finance care or budget to purchase insurance.

Employer Response

Employers' response to this new understanding has been mixed. New employee benefits, usually provided through employee assistance programs, have been formulated to assist workers in caring for disabled dependent parents, spouses and children. These programs include financial planning services, personal and family counseling, support group therapy, service referral and assessment and placement services, as well as adult day care. Flexible hours and leave arrangements also assist workers with disabled dependents. In addition, a growing number of employers are looking to more orthodox insurance models to help employees finance long-term care.

Employer experience with retiree health insurance

The employer cost of providing health insurance to active workers, retirees and dependents has been increasing at rates two to four times the rate of general inflation. With plan costs uncontrolled despite employers' attempts, health insurance has become a significant source of unpredictable labor costs. Not surprisingly, employers have devoted substantial attention to attempting to limit and control their health plan liabilities.

New accounting standards, currently under development by the Financial Accounting Standards Board (FASB), are likely to force employers to focus on a variety of issues concerning their retiree medical benefits. In an exposure draft to be issued later this year, FASB is likely to require that employers estimate accrued liability for retiree health benefits, and include unfunded liability as a balance sheet entry; funding would become an income statement expense. For many firms unfunded liability for retiree health benefits is substantial relative to assets; annual plan expense is a significant percent of active worker pay. The anticipated FASB accounting rules could jeopardize their ability to raise capital and maintain present employee benefit programs. For publicly owned firms, bond and stock prices are likely to be adversely affected as lower corporate earnings are reported. New accounting procedures recognizing accruing liability for retiree health insurance could influence employers' willingness or ability to assume responsibility for paying long-term care insurance premiums.

Long-Term Care As An Employee Benefit: An Emerging Market

Interest in long-term care insurance among the public and among insurers has grown substantially, raising the number of policy options and policy holders more than four-fold in the past few years. At least nine large employers have established long-term care as an employee-pay-all benefit, enabling access to coverage by tens of thousands of employees. Most of these plans recognize employees' parents as qualified dependents.

This market has emerged against overwhelming odds. Products have been structured and priced without sound actuarial data. State insurance regulations and federal tax laws are confusing and ambiguous. Recognizing that most states have no laws explicitly governing long-term care insurance, the National Association of Insurance Commissioners (NAIC) developed a model act and regulations to assist state legislators. At this time, 25 states have enacted some type statute governing private long-term care insurance; 15 have based their legislation on the NAIC model act. Another seven states have pending legislation based on the NAIC model.

Ambiguity in the Internal Revenue Code regarding the tax status of long-term care insurance reserves has affected the pricing and selling of insurance products. By one estimate, premiums could be as much as 11 percent lower for insurance purchased at age 65 if long-term care insurance reserves were given the same tax status as life insurance reserves.[1] For consumers, it has not been clear whether either the benefits received or the premiums paid would have the same tax treatment as other health insurance benefits or premiums.

Other barriers to consumer interest in purchasing commercial long-term care insurance include: (1) confusion about the long-term care coverage provided by accident and health insurance, Medicare, retiree health plans, Medigap policies, and Medicaid; (2) ignorance or confusion about the lifetime risk of incurring a disabling condition; and (3) denial by many individuals that life contains this contingency. The anticipated cost of public education necessary to market commercial long-term care insurance has been a significant barrier to market development.

Nevertheless, this market is emerging without a full understanding among providers or policy makers of what constitutes effective long-term care delivery, how alternative forms of reimbursement affect delivery, how to objectively assess patient needs, or how to coordinate care among different providers and sites. Finally, this market has emerged without clear legislative signals from the Congress.

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[1] U.S. Department of Heath and Human Services, "Catastrophic Illness Expenses." Report to the President, p. 78 (November 1986).

The limitations in the policies developed so far reflect insurers' hesitation to commit to long-term care insurance products. Although many insurers are attracted by the profit opportunities of a new insurance line, they recognize the difficulty of limiting their financial liabilities yet offering a product attractive to consumers.

Long Term Care Insurance as an Employee Benefit

Insurers' tentativeness about entering the long-term care market has been matched by employers' reluctance to institute new benefits or to assume additional health care financing obligations for workers and retirees.[2] Frequent and pervasive legislative changes affecting their tax-qualified plans have exacerbated their apprehensions about providing long-term care insurance.

Nevertheless, in the last two years, at least nine employers have offered access to a long-term care insurance product to some part of their current or former workforce. At least six additional employers have publicly expressed their intention to sponsor long-term care insurance. A recent survey of 144 large companies indicated that 55 of these companies had or were then investigating the feasibility of long-term care as an employee benefit. Among those who had not, 38 companies anticipated conducting an evaluation in the next two years.[3]

Employer-sponsored long-term care plans typically have been made available to active workers, their parents, and retirees. With one notable exception, employees pay the entire premium. Separated employees have been able to continue coverage by paying the premium at the same rate plus a charge for administrative cost.

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[2] Issues related to financing long-term care as an employee benefit are discussed in D. J. Chollet and R. B. Friedland, "Employer Financing of Long-Term Care." In R. M. Scheffler and L. F. Rossiter, eds. Private Sector Involvement in Health Care: Advances in Health Economics and Health Services Research 9 (Greenwich, CT: JAI Press, 1988).

[3] R. Levin and R. Frobom, The Corporate Perspective on Long-Term Care: Survey Report (Appendix 2) (Washington, DC: Washington Business Group on Health, 1987).

Annual premiums are typically age-related, ranging from $120 to $158 for individuals purchasing at age 30, and $204 to $384 for individuals initially purchasing coverage at age 50. In at least one of these plans, the premium for an initial purchase at age 75 is $1,800 a year.

For nursing home care, these plans pay $50 to $100 per day; for home health care, they pay $20 to $50 per day. Some plans do not pay for care necessitated by Alzheimer's Disease.

Each plan limits plan liability, typically imposing a lifetime maximum of four years of nursing home care (or the dollar equivalent) and a 90-day deductible or exclusionary period. Some plans offer an option to index benefits, accommodating increases in the cost of care; some will return part of the premium if the covered person dies before using any benefits. Preliminary information suggests that the average age of the purchasers of this employment based coverage is about 40.

So far none of these products have been true group products: individuals can be denied coverage due to an existing or past medical condition. Nevertheless, these products offer the consumer considerable savings over searching for and purchasing individual products. In particular, the costs of administration (unless the employee leaves the firm) and, more substantially, the marketing expenses (including sales commissions) are less and are likely to be paid by the employer.

Goals of a System of Long-Term Care Financing

In debating alternative systems of long-term care financing, a number of general goals can be articulated for any system. These include:

- The development of an insurance system. By spreading the cost of long-term care need among a larger population than those immediately at risk, insurance would rationalize long-term care financing. This insurance system may be mostly private, mostly public, or a combination of private and public.

- Adequate coverage. Adequate coverage would guarantee access to needed care without imposing on participants unreasonable levels of uninsured, out-of-pocket expense.

- Universal access. The system should be accessible to all members of the population. This goal raises issues of affordability for participants. If the system relied on asset accumulation to finance long-term care, this goal also raises issues of portability and asset preservation. Finally, it raises the question of coordinating long-term care financing with individual retirement saving and pensions (for example, targeting pension annuities for long-term care insurance).

- Flexibility. Any financing system should accommodate individual preferences for alternative forms of service delivery, including community-based care, institutional care, and composites of residential, medical and personal care services such as life-care communities. The system should also recognize families and assist them in providing long-term care.

- Efficiency. Any financing system should pay providers in a manner that encourages cost-efficient service delivery and readily accommodates technological change.

Any of a number of alternative financing systems might meet these goals. S. 2305 would encourage a mixed, private-public insurance system. To encourage the private market, the bill would clarify various tax code provisions related to employer-sponsored and individual long-term care insurance plans, extending to qualified plans the same tax treatment as health insurance. Qualified plan reserves (contributions and earnings) would be tax exempt, in the same manner as life insurance reserves are exempt, lowering premiums and encouraging wider participation. Conceivably, acute and long-term care coverage could be underwritten in the same insurance plan, expanding case managers' options in planning care for high-cost cases. Also, S. 2305 establishes employer-based long-term care insurance as a welfare plan, presumably extending ERISA protections from state taxation and regulation and establishing fiduciary standards for plan administration. By establishing long-term care as a qualified cafeteria-plan benefit, S. 2305 also allows employer-based plans to be wholly or partially employee-financed with pre-tax earnings.

However, S. 2305 does not clearly address issues that relate to ensuring that workers have long-term care coverage at the point of greatest probable need: after retirement. Current employer group products rely on asset accumulation. Premiums are priced according to the participant's entry age (older new participants pay more for coverage than younger new participants) and participants can maintain coverage by continuing premium payments after they separate from the group. Since these plans are relatively new, we have no experience to suggest the rate at which terminated employees actually continue coverage. Experience with employees failing to transfer preretirement lump-sum pension distributions into tax-qualified individual retirement accounts, however, is not promising. It is likely that a significant number of workers who separate from a long-term care insurance plan will fail to continue payment if they anticipate no immediate need for benefits. In the context of private pensions, the Congress is now considering issues of asset preservation and portability to ensure an ultimate stream of income for retirees in return for tax incentives (S. 1349). These issues are critical components of other programs designed to provide economic security for retirees.

Conclusion

The Committee faces a difficult challenge as they confront the complexities of this issue. Senator Mitchell has articulated some major issues clearly:

> The policy issue we face is how to target our limited resources to the elderly that are most in need.... I believe that the insurance industry will respond to the demand for long-term care insurance with the development of policies to meet the needs of our aging population.

Through tax incentives, the federal government now encourages a substantial and growing system of pension provision for retirees. That system provides an important part of the income that could pay for long-term care insurance and now helps finance long-term care services.

We commend the Committee for undertaking the challenge of structuring a workable system of long-term care financing in the United States, and stand ready to assist the Committee in its efforts.

Testimony of
GAIL SHEARER
MANAGER, POLICY ANALYSIS
CONSUMERS UNION

Mr. Chairman and members of the Subcommittee, Consumers Union* appreciates the opportunity to present our views on the Long Term Care Assistance Act of 1988. We commend Senator Mitchell for his leadership on this important issue.

The Long Term Care Assistance Act would provide nursing home coverage (after a two-year waiting period), home care, and respite care benefits. All benefits would be available to Medicare beneficiaries only, and would require substantial cost-sharing.

My testimony today will focus on the role private insurance would play under the Long Term Care Assistance Act of 1988. The key points are as follows: First, the private long-term care insurance market is not presently meeting consumers' needs and will not do so in the future without substantial government intervention. Second, there are several very good policy options for improving market performance to enable it to meet consumers' needs. Finally, I include several comments on the bill's financing mechanism, implications of the two-year deductible, and proposed beneficiaries.

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POOR PERFORMANCE OF THE PRIVATE LONG-TERM CARE INSURANCE MARKET

A key premise of Senator Mitchell's proposed bill is that the private insurance will be marketed (and purchased) more aggressively to protect consumers against the uncovered costs of the first two years' nursing home stays. Consumers Union believes that if Congress chooses to allow the private insurance system to be a major player in the solution to the long-term care problem, then Congress must take unusually strong steps to assure that the private market provides high value products. Neither the unguided free market nor the current National Association of Insurance Commissioners (NAIC) regulations will be sufficient to improve the performance of this market.

In May 1988, Consumer Reports published an in-depth evaluation of 53 private long-term care insurance policies. (A copy of the article and Consumers Union's "Long-Term Care Maze" are attached to my testimony.) What we found was disappointing. All 53 of the policies we looked at had at least one major flaw. All of the policies were expensive. Some of the key findings of the article were:

-- People with existing health problems are often denied coverage. Some companies reject as many as 30 percent of applicants; others have waivers for pre-existing conditions.

-- The policies are expensive, with premiums for a 65-year-old as much as $100 a month, and for a 75-year-old as much as $260 a month. Companies are free to raise the premiums charged to policyholders.

-- Some policies cover only skilled and intermediate care, and not custodial care -- the potentially longest lasting kind of care. Many others restrict the benefits for custodial care.

-- While 61 percent of patients enter a nursing home without being hospitalized, 72 percent of the policies examined by Consumer Reports required prior hospitalization before any benefit could be provided.

-- Few policies had protection against inflation, which can seriously erode the value of the policy over time. Only one company had built-in inflation protection, and less than half offered an optional inflation rider.

-- More than half of the policies evaluated had vague language that could be used to deny coverage for people with Alzheimer's disease.

Another disconcerting fact about private long-term care insurance is the amount of money that is diverted (from the pool of funds available for benefits) to pay for the costs of marketing, administration and profits. 40 to 50 percent of premium dollars are expected to go towards these costs. If the medicare supplement insurance market is any guide, some companies will need even more money for marketing, administration and profits. We are disturbed by these facts, and they have encouraged us to seek public policy options that would enable us to get more bang for the long-term care buck.

Another disturbing conclusion one must draw from the Consumer Reports article is that the variation in policy options is overwhelming to the average consumer, and denies the consumer the opportunity to compare the merits of alternative policies in a rational and effective way. Attached to my testimony is a table that shows many of the ways that the long-term policies Consumer Reports examined vary. For example, daily policy benefits range between $40 and $100, or might be a percent of actual charge, or might vary by level of care. Inflation protection varies. Type of facility included varies (e.g., skilled nursing, intermediate, custodial, home). Requirements for prior hospitalization (or prior care at a skilled facility) vary.

The degree of variation does not serve consumers well. Consumers are precluded from comparing the prices of similar policies -- too many things vary from one policy to another.

OPTIONS FOR IMPROVING PRIVATE MARKET PERFORMANCE

We recognize that budget constraints may force Congress to enact a long-term care program that does not cover all of the long-term care costs. In the interest of providing constructive suggestions, I will outline three options for enabling Congress to significantly improve consumers' "bang for the long-term care buck" without burdening the federal budget beyond what is proposed in Senator Mitchell's bill.

Voluntary Medicare Part C

Under this option, the Medicare-eligible could buy (voluntarily) long-term care protection through the Medicare program, in a way similar to Part B. However, unlike Part B protection, 100 percent of the costs of the program would be paid through the premium. There is no question that the premium would be high, but should compare favorably with private insurance premiums since the Medicare program has a solid history of very low administrative costs of three percent. In contrast to the relatively low-efficiency of the private market, Medicare returns 97 percent of revenues collected in the form of benefits.

Premiums could be scaled to income, or partly "flat" and partly income-related as in the catastrophic bill and the Long Term Care Assistance Act). If income-related, there should be a cap on the maximum premium in order to encourage participation by higher income people.

Karen Davis, Ph.D., and Diane Rowland, M.P.A., (professor and research associate, respectively, at the Johns Hopkins University School of Hygiene and Public Health) proposed an optional Medicare Part C to cover nursing home care, home health services and day hospital services. [Karen Davis and Diane Rowland, Medicare Policy: New Directions for Health and

Long-Term Care, The Johns Hopkins University Press, Baltimore, 1986] Under their proposal, coinsurance would be set at 10 percent, and out-of-pocket expenses limited to $3000 per year. People would be eligible to enroll for the coverage at age 60, but benefits would not be initiated until a person had enrolled for at least five years. Premiums would be 4 percent of income for those enrolling at age 60, and would increase for those postponing enrollment.

Competitive Selection of Private Company(ies) to Sell Government-Designed Policies

The second option could also have relatively low administrative costs but could allow for a larger private sector role in implementing the program. Under this approach, the government (presumably the Department of Health and Human Services, following the direction of the Congress) could design a standard long-term care policy, with three or four option levels (e.g., low, medium, high, each covering different dollar amounts of coverage) and would allow private insurance companies to bid for the right to market the policy on behalf of the government. Competition could be set up regionally, thus allowing several companies to participate. The companies that would "win" the right to market the policy would be those that could assure that they would not divert substantial funds away from the money available to pay benefits.

This proposal is similar to an option explored recently in Massachusetts to develop a state long-term care insurance plan that could be administered by private insurers. [See Beyond Chaos and Catastrophic Costs: A Long Term Care Plan for Massachusetts Elderly, Report of The Special Commission on Elderly Health Care, April 1987, pages 39 - 45]

Standardization of Private Insurance Market

The third public policy option could provide an even greater role for private insurance companies and is likely to significantly increase the value consumers receive for their long-term care dollars. This option involves standardization. Under standardization, the government would establish uniform definitions for key policy terms (e.g., terms such as skilled nursing facility and custodial care facility) and restrict the variations allowed for other insurance policy provisions (such as length of waiting period or inclusion of home care). Policy standardization should be distinguished from "minimum standard" types of regulation. With minimum standards, insurers are free to offer benefits greater than the minimum standard. With standardization, no such variation is allowed.

The goal of standardization would be to limit the policy features that vary from one policy to another to simplify the market and facilitate price competition. While restricting consumer choice on most policy features, the regulation should seek to offer significant differences in the one or two policy features that do vary. For example, standardization of the long-term care market might include:

- standard definitions of terms such as skilled nursing facility, intermediate nursing facility, custodial nursing facility;
- uniform waiting period (e.g., 20 days);
- benefit levels that are uniform for different types of facility offered by any one policy;
- proportional benefit (e.g., 50 percent of nursing home benefit) for home care;
- no prior hospitalization requirement;
- coverage of Alzheimer's disease;
- automatic inflation adjustment;
- guaranteed renewable;
- waiver of premium.

Once all of the above features were standardized, regulators could develop three or four varying levels of the benefit level. For example, the daily benefit level options could be:

Option	Benefit level
LTC1	$50 per day
LTC2	$75 per day
LTC3	$100 per day

Consumers could consider what benefit level they desire and then compare prices of similar competing policies. Not only would consumers benefit directly and be less confused, but this simplification of the market should greatly reduce marketing costs and lead to higher value products.

The private sector "solution" does have some serious drawbacks. First, unlike the Medicare Part C approach, premiums would be flat (*i.e.*, unrelated to income). This is the most regressive type of financing, and would keep private policies out of reach of people with low and moderate incomes. The second drawback is that insurance companies could screen out relatively high risks, protecting themselves against adverse selection. Both of these problems have solutions: explicit subsidization of premiums and mandatory open seasons, respectively. But at some point, Congress must consider whether a larger direct government role is preferable to such a heavily regulated private role.

Inflation presents a third problem area for the private sector. The private market is not able to handle inflation well since premium revenue (unlike the payroll tax) does not automatically grow with inflation.

The State of Massachusetts adopted a standardization approach for the medicare supplement insurance market. The regulation established three levels of medigap coverage. All medigap policies sold in Massachusetts are required to comply with one of the three benefit options and can not be modified. The regulation has been extremely effective. In 1984, *Consumer Reports* rated the most popular medigap policy sold in Massachusetts as the top medigap policy in the country.

[Consumer Reports, June 1984, p. 347] In 1986, the General Accounting Office reported that the Massachusetts Blue Cross/Blue Shield Medex individual policies had a 1984 loss ratio of 98 percent, thus assuring consumers an extremely high value insurance product.

OTHER CONCERNS ABOUT S.2305

People under age 65

While the need for long-term care increases dramatically with age, millions of people under 65 also need long-term care. Their long-term care needs may be caused by a birth defect, rare disease, trauma, or other catastrophe. According to the 1985 National Nursing Home Survey, 11 percent of nursing home admissions are for people under age 65. Projections for the year 2000 indicate that 40 percent of functionally dependent Americans will be under 65. It can be argued that the relatively low probability of needing long-term care at a young age makes social insurance even more appropriate for it than for long-term care for people over 65. We urge you to expand your discussion to include protection for all Americans, regardless of age. We understand that this will have cost implications.

Burden of a Two-year Deductible

We note that this legislation (in particular if it is not amended to improve the private market performance) benefits only people who have assets sufficient to cover the cost of two years in a nursing home. On average, this will cost at least $44,000 nationwide, but closer to $90,000 or more in Washington D.C. and other urban areas. The impoverization of the middle class by long-term care costs is an important public problem, and we commend you for addressing it. At the same time, we urge you to keep in mind that this legislation does not help the average American, who faces poverty after just 13 weeks in a nursing home.

ATTACHMENT

TABLE
VARIATION IN PRIVATE LONG-TERM CARE INSURANCE POLICIES EVALUATED IN CONSUMER REPORTS

Provision	Range or Description of Variations
Daily benefit for care in a covered facility	-- $40 to $100/day; -- Some policies pay 80% of actual charges up to $80/day; -- 1 policy pays 100% of actual cost; -- 1 policy pays 100% of eligible charges up to $75/day; -- 1 policy pays $75 for skilled care, $50 for intermediate care, and $25 for custodial care.
Waiting period (the number of days a policyholder must be in a facility before coverage begins)	-- 0 days to 100 days.
Maximum benefit for each period (*i.e.*, one stay in a nursing home)	-- 730 days to unlimited days or -- $60,000 to unlimited dollars.
Maximum benefit for all periods (i.e., all nursing home stays)	-- 730 days to unlimited days or -- $60,000 to unlimited dollars.
Coverage of skilled nursing facility care	-- Covered by all policies, but: -- One policy pays half benefits for first 50 days, with no waiting period; -- One policy pays for custodial care only in a skilled facility.
Coverage of intermediate nursing facility care	-- Most but not all policies cover; intermediate care, but: -- For some policies, coverage depends on company's interpretation; -- Some policies have shorter benefit period for this care; -- Some policies have reduced daily benefit for this care; -- One policy covers only custodial care provided in an intermediate care facility.
Coverage of care in a custodial care facility	-- Several but not all companies offer some coverage; -- Three companies had shorter benefit period for custodial care; -- Five companies paid benefits only after pre-confinement in skilled or intermediate care facility, with reduced benefits that are paid over a shorter period.
Coverage of home care	-- More than half of the policies cover home care, sometimes as part of basic package but often as a separate rider;

Financing

We strongly support three parts of the financing package: repealing the Medicare wage cap ($45,000 cap at 1.45 percent), the 5 percent surtax on estate transfers exceeding $200,000; and the income-related supplemental premium. We also support imposing increased Medicare premiums -- both flat and income-related -- to finance long-term care costs. However, in light of the distribution of the benefits to relatively well-to-do elderly (with assets exceeding $44,000), we urge you to consider exempting relatively low-income elderly from the additional $2/month Part B premium. Another potential revenue source that could be tapped for expanded benefits for people under age 65 is a broad-based increase in the payroll tax.

Thank you very much for the opportunity to present our views on this important legislation.

	-- Definitions of what "home care" covers varied: most covered convalescent care, homemaker or companion services; some covered skilled nursing care; a few included care in hospices and adult day-care centers; -- The benefit is typically one half the daily benefit paid for skilled or intermediate care; -- Some policies require previous nursing home or hospital confinement and would cover home care only if its starts within 14 days after leaving the nursing home or hospital; -- Other policies do not require prior hospitalization or nursing home care, and apply the regular waiting period.
Prior hospitalization	-- 72% of the policies require a hospital stay of at least 3 days before entering a nursing home; the others do not.
Alzheimer's Disease	-- Some policies clearly state that Alzheimer's disease is covered (though in most cases coverage is subject to the prior hospitalization requirement); -- Vague policy language leaves ambiguity about Alzheimer's coverage of many policies.
Inflation adjustment	-- One company has built-in inflation protection; -- A few companies pay benefits based on actual charges; -- Some companies offer an inflation rider that protects against inflation; -- Most policies offer no protection against inflation.
Renewability	-- Many policies are "guaranteed renewable" (i.e., the company must renew coverage each time the policyholder pays the premium); -- Some policies are "conditionally renewable," allowing the insurer to cancel the policy if it cancels all similar policies in the state.
Waiver of premium	-- Some (but not all) policies allow policyholders to stop paying premiums once they have been in a nursing home for a certain period.

Who can afford a

This year, 2.3 million of the nation's elderly will be living in a nursing home. Three decades from now that number will nearly double. A year in a nursing home now costs on average $22,000 or more. By the year 2018, it will cost about $55,000 if inflation stays at recent moderate rates.

Who will pay the bill?

Medicaid, the Federal program that finances health services for the poor, paid half of the $38-billion that went into nursing-home care in 1986. Most people aren't poor when they enter a nursing home, but they become poor soon after.

The other half of the $38-billion came out of the pockets of nursing-home residents or of their children, who often find themselves squeezed between the financial needs of their own family and the burden of caring for aged parents.

Contrary to popular belief, Medicare, the Federal program that provides health care for the aged, pays only a tiny fraction of the cost of nursing-home care.

The Reagan Administration believes that the Federal government has no role to play in providing long-term care unless you're poor. The nonpoor, it tells us, should look to private insurance companies for protection against the potentially devastating financial consequences of a prolonged stay in a nursing home. As a result, long-term-care insurance policies, unknown until a few years ago, have proliferated. Currently, some 70 companies, ranging from familiar giants like Aetna and John Hancock to lesser-known firms like Reserve Life and Pilgrim Life, have entered the field. For this report, we analyzed 53 of their policies.

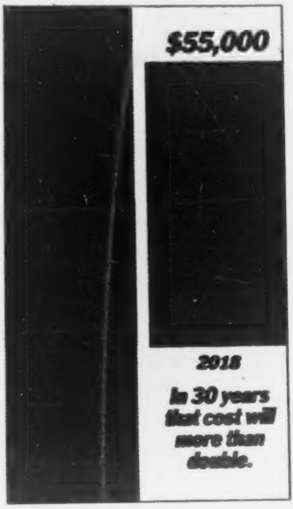
We'd like to report that private insurance policies can meet the increasingly urgent need for long-term-care coverage at a moderate cost. But many of the insurance policies we looked at were very expensive, severely limited in their coverage, or both. People who buy them at age 65 may have to pay as much as $100 a month for adequate coverage. People who try to shop for them will run into a crazy quilt of charges, waivers, and limitations that confuses even the insurance agents who sell the policies.

Illustrations by Pelco
Charts by Corinne Abbazia Hekker

Defining the policy

Simply stated, long-term-care insurance pays a set amount each day for a specified period of time that a policyholder stays in what's called a "covered nursing facility." Unlike other kinds of health insurance, these policies usually don't reimburse the policyholder for fees actually charged. The fixed benefit is one major drawback of nearly all such policies. Should you buy a policy today and enter a nursing home 10 years from now, you may find that the benefit pays a much smaller part of the actual cost than you thought it would at the time you bought the policy. Only a few policies offer a rider that adjusts the benefit annually for inflation.

Furthermore, you'll find huge differences in dollar benefits, in definitions of covered nursing facilities, in the length of time benefits are paid, in limitations on coverage, and in eligibility for benefits. Those differences are spelled out in the Ratings on page 304.



In 30 years that cost will more than double.

Type of facility covered

There are three types of long-term-care facility: skilled, intermediate, and custodial. A policy may or may not cover care in all three types, and different policies may define the three types of facility differently. In general, the definitions are the following:

Skilled nursing. Such care must be prescribed by a doctor, given by a skilled nurse, and be available for 24 hours a day. These facilities are licensed by the state, and daily medical records are kept on each patient.

Intermediate. In such facilities, care may require the skills of a nurse, but the level of care is somewhat less than that given in a skilled-care facility. For example, a nurse may be on hand only to give patients injections or to change their bandages. The facility may be licensed and may provide post-hospital and rehabilitative nursing care.

Custodial. Care here means helping a person with such routine activities as getting out of bed, walking, eating, and bathing. It may be given by people without professional skills or training, but some insurance policies may require that the facility be licensed.

The best policies pay benefits for all three kinds of care in all three types of facility. Buy less than the best, and you may discover that your insurance doesn't cover the type of care you require.

Note that policies can imply coverage where none exists. For example, a policy might provide coverage for all three *types* of care, but require that the care be given in only *one* type of facility, such as a nursing home that provides skilled care.

Custodial care is sometimes covered only if it is provided in a skilled- or intermediate-nursing facility. Some policies pay no benefits for custodial care, no matter where it's given. That's a major deficiency. Very few people need skilled care for long periods; much of the care in nursing homes is of the intermediate or custodial variety. Stroke victims, in particular, often require a long period of custodial care while recovering.

Qualifying for benefits

Most policies require beneficiaries to be hospitalized for at least three days before

nursing home?

they enter a nursing home. And usually the nursing home must continue to provide care for the illness or condition that put the individual in the hospital.

Furthermore, the person must check into the nursing home within a certain period after checking out of the hospital. That period is usually 30 days, but it can be as short as 14 days or as long as 90 days. These rules can limit the usefulness of the insurance. Such debilitating conditions as arthritis and Alzheimer's disease usually do not require hospitalization. Only about 40 percent of all nursing-home patients check in after a hospital stay.

A few policies do not demand a hospital stay before paying benefits for long-term care. But the companies that issue them, including Blue Cross/Blue Shield and Metropolitan Life, do retain the power to decide who is eligible for benefits. Some companies, including MidAmerica and Continental Casualty, offer buyers a choice of policies with and without "prior-hospitalization" rules. Of course, the ones without these rules generally cost more.

We found nine policies free of either the prior-hospitalization rule or the company's veto of a policyholder's eligibility for nursing-home coverage.

Other restrictions may stand in the way of custodial care, which is potentially the longest-lasting and hence the most costly type of care. John Hancock's individual policy, for example, pays for care in a custodial facility only after 14 continuous days of skilled-nursing care. Aetna pays for a policyholder's first stay in a custodial facility only after a stay in either a skilled or an intermediate-care facility.

What's not covered?

No policy pays benefits for stays in rest homes or old-age homes. Nor do they pay for stays in mental hospitals or alcohol and drug rehabilitation centers. Most significantly, long-term-care policies tend to limit benefits for existing health problems and for Alzheimer's disease, the very reasons people might seek coverage in the first place.

Most companies limit coverage for "preexisting conditions"—those illnesses or diseases a buyer has when the policy is issued. The preexisting-conditions clause acts as a gatekeeper, turning away those who want to buy the coverage because they know they need it. If a company does not have a preexisting-conditions clause, it usually retains the power to decide who's eligible for benefits.

Most policies define a preexisting condition as any health problem experienced by the policyholder in the six months prior to buying the policy. But a number of policies count back one to three years.

If the insurance company sells a policy to a person with such a preexisting condition, it sets a waiting period before coverage for that condition can begin. These periods range from six months to two years. So if a heart condition lands someone in a nursing home three months after the policy was issued, the company won't start paying benefits immediately.

Virtually all the policies exclude care for mental and nervous disorders. Does that include Alzheimer's disease, a debilitating condition that's diagnosed in about half of all nursing-home patients?

Although Alzheimer's is not specifically excluded, about half the policies we looked at said something like "we won't pay for confinements due to mental illnesses except those with demonstrable organic disease." Alzheimer's disease is a degenerative brain disease with symptoms that mimic those of mental illness. It's considered an organic disease and therefore would seem to be covered. But is it a *demonstrable* organic disease? Only a biopsy or an autopsy can confirm a diagnosis of Alzheimer's disease.

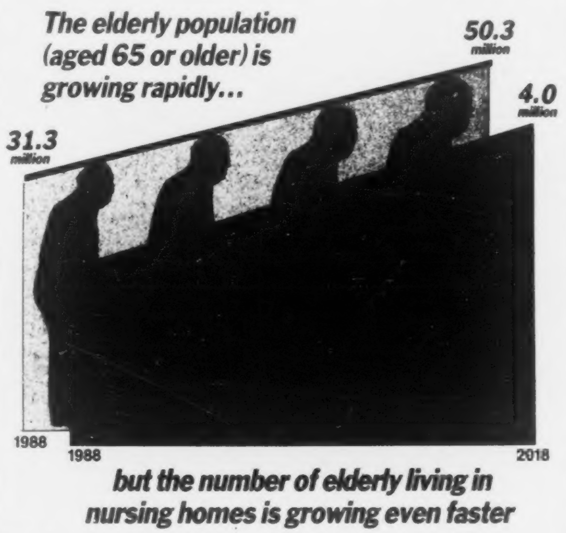
In our opinion, the vague policy language gives insurance companies too great an opportunity to contest a claim on the grounds that Alzheimer's disease has not been demonstrated. A company suddenly flooded with claims from policyholders with Alzheimer's disease might rely on that language as a basis for denying nursing-home coverage.

Other policies clearly state that Alzheimer's disease is covered. But here, again, there's a catch. Many of these policies also impose the prior-hospitalization rule. Most Alzheimer's patients, as we've noted, do not require hospitalization before they enter a nursing home.

When we asked an Aetna salesman about this, he replied: "To tell you the honest-to-goodness truth, if a doctor didn't find some way to get you into a hospital, then you're in trouble."

How large a benefit?

Daily benefits range from $25 to $100. Some policies offer a choice of benefit amounts. Obviously, it makes sense to pick a policy with benefits that closely match local nursing-home costs. A policy



Source: Brookings Institution

paying $40 a day when the local nursing home costs $140 isn't much help. A call to two or three homes will help to establish a reasonable range of daily charges. Nationally, the average cost of a nursing home is $60 a day.

Sometimes insurance companies pay smaller benefits for custodial care than for skilled and intermediate care. The Gerber Life policy, for instance, pays a $75 benefit for skilled-nursing care, a $50 benefit for intermediate care, but only $25 if a policyholder needs custodial care.

When do benefits begin?

Policyholders can often decide when they want their coverage to start—as soon as they enter a nursing home, 20 days later, or even 100 days later. The longer this "waiting period" (sometimes called an elimination period), the cheaper the policy.

How long do benefits last?

The best policies pay benefits for an unlimited number of days for each stay in a nursing home and an unlimited number of days for all nursing-home stays. Those stays in a nursing home are sometimes called "periods of confinement" or "benefit periods."

Other policies pay benefits for a specific number of days, ranging from 730 (two years) to 3650 (10 years) for one stay, and from 730 days (two years) to 2555 (7 years) for all nursing-home stays. A few policies don't limit the number of days they'll pay benefits. They set dollar maximums instead.

In order to receive benefits for a repeat stay in a nursing home, the policyholder must usually have been out of a nursing home for at least 180 days. And when he or she returns, the waiting period starts all over again, so coverage doesn't begin immediately. Waiting periods for preexisting conditions don't begin again, however.

Sometimes a policy will have a shorter benefit period for intermediate or custodial care than for skilled-nursing care. This could be a severe limitation, since nursing-home patients require skilled care less often than intermediate or custodial care. Nearly 40 percent of all nursing-home patients stay longer than six months. Chances are good that those longer-staying patients needed intermediate or custodial care, not skilled care.

Are policies renewable?

Many policies are "guaranteed renewable," a desirable feature that insurance companies like to highlight in their sales literature. The company must renew coverage each time the policyholder pays the premium.

Beware of policies that are only "conditionally renewable." The insurer can cancel the policy provided it also cancels all other similar policies in a state. That could happen if an insurance company discovers it is losing money on this relatively new type of coverage.

A number of policies are written for groups such as the American Association of Retired Persons (AARP), or even for a fictitious group set up by the insurance company for marketing and regulatory purposes. The group holds the master contract and issues certificates to individual policyholders. The master contract for the group can be canceled, but policyholders are often able to continue the same coverage on their own.

What else to look for?

Here are other features we looked for in a policy:

Home care. More than half the policies in our study paid benefits for care at home. These benefits are usually offered as part of the basic policy coverage, but sometimes they are offered as a separate policy or as a rider at an additional premium. Home care typically covers convalescent care, homemaker or companion services, and occasionally even skilled-nursing care. A few policies define home care broadly enough to include care in hospices and adult day-care centers.

Typically, the home-care benefit is one half the daily benefit paid for skilled nursing or intermediate care, but that's where the similarity among policies ends. There's wide variation in eligibility for home-care benefits and in when those benefits begin and end.

Policies that require previous nursing home or hospital confinement would usually pay for home care only if it starts within 14 days after leaving the nursing home or hospital. Policies that do not have such a requirement would generally start paying as soon as the regular waiting period has ended.

Continued on page 304

What's in a good policy?

Features	*Recommended*	*Your policy*
Daily nursing-home benefit	**$80.00**	$
Waiting period	20 days	
Maximum benefit period for one stay	**4 years**	
Maximum benefit period for all stays	Unlimited	
Does it pay full benefits in:		
Skilled-nursing facility?	**Yes**	
Intermediate facility?	**Yes**	
Custodial facility?	**Yes**	
(If not, what does it pay?)		
If it has a prior-hospitalization rule, does coverage begin within 30 days after a hospital stay of at least 3 days?	Yes	
Does it pay home-care benefits?	**Yes**	
Does it pay these without requiring nursing-home care, or a hospital stay?	**Yes**	
Does it have waiver of premium?	Yes	
Is it guaranteed renewable for life?	**Yes**	
Is Alzheimer's disease covered by specific policy language?	Yes	
Does the premium stay level for life?	**Yes**	
What is the Best's rating of the company?	A or A +	
No premium is recommended; premiums vary with the age of the policyholder:	—	$

Pitching the policies

It has never been easy to understand insurance policies. It's even tougher when the agents selling them don't understand what they're selling. And when the policy sold is brand-new, it takes a miracle to avoid misunderstanding, duplication of coverage, or even inadequate coverage.

A CONSUMER REPORTS reporter listened to sales pitches given by six insurance agents in New York and Virginia. Two agents represented Aetna; the others represented Union Bankers, Bankers Life and Casualty, Gerber Life, and Mutual of Omaha. Our reporter witnessed no miracles.

She found confusing presentations from agents who were either ignorant of the provisions in their policies or who deliberately misstated them. An Aetna agent in Virginia admitted, "I've never had to explain this to someone." Some agents were remarkably low key, acting as if they didn't want to sell the policy.

Alzheimer's confusion

About half of all nursing-home patients suffer from Alzheimer's and related diseases, so shoppers would want to know whether a policy provided coverage for such illnesses. They wouldn't have found out listening to these agents or reading their sales brochures. The agents' confusion may well reflect their company's indecision over whether to provide such coverage.

The Aetna agent in Virginia allowed that "it was questionable" whether his policy covered the disease, but said the company was "still looking at it." He added, "It's a mental disease, and they're not sure."

No wonder he was confused. The sales brochure sent by Aetna said Alzheimer's was covered, but the actual language in the policy was less specific. It said that the policy did not cover confinements for mental disease or disorders without demonstrable organic disease. As we point out on page 301, that language may or may not mean the disease is covered.

The Union Bankers agent said Alzheimer's was covered, but the brochure he left noted that the policy didn't cover nursing-home stays for "mental illness or nervous disorders." Did that mean Alzheimer's is covered? Our reporter could only guess.

What's covered?

Coverage is the guts of a long-term-care policy, but agents were of no help defining the coverage or discussing the policy limitations. Here's how the Aetna agent in New York handled these questions:

What about intermediate-care coverage? The agent fumbled for his sales brochure and replied: "They define it here somewhere." What about skilled nursing care? "On this plan, you don't have to worry about the definition," he assured us.

As for limitations on coverage, he said there were none. "Once you have this policy, you're covered for everything." Everything? The policy specifically says it does not provide benefits for six months if a nursing-home stay results from a preexisting condition.

A competitor also had trouble explaining coverage. The agent from Bankers Life and Casualty said that intermediate care was the same thing as "convalescent care" and that skilled care meant that "they do a little more medical than the others."

When asked whether any prior hospitalization is required before skilled-nursing benefits could be paid, the agent for Mutual of Omaha said: "I don't think so. I've never seen where you have to be hospitalized first." He didn't look very far. That's just what his company's sales brochure said.

What Medicare pays

Many people think that Medicare covers nursing-home stays (see box page 311). Actually, it pays for skilled nursing-home care in Medicare-approved facilities for only 20 days and then all but $67.50 per day for the next 80 days. After 100 days, Medicare pays nothing.

Here's what the agents said:

The Gerber Life salesman said that 70 percent of all applicants for Medicare benefits were turned down "because Medicare doesn't have funds for skilled care." But when Medicare does accept an individual, he said, "after 100 days, they wash their hands of you."

The Bankers Life and Casualty agent said that Medicare paid for 100 percent of home health-care costs. "It's a wonderful benefit," he said, declaring that Medicare pays "for girls to come in" and "help do your hair."

The agent had let his imagination run away with him. Medicare's home-care benefit is very limited, and it certainly doesn't pay for beautician services. It pays only for part-time, intermittent skilled care and for physical or speech therapy. The provider must participate in Medicare.

What about rate hikes?

It wasn't always easy to get a straight answer about whether premiums could go up or policies could be renewed.

The Bankers Life and Casualty agent incorrectly said the premiums would never increase, wrongly labeling this policy feature as "guaranteed renewable." The policy and the sales brochure say that the company can raise premiums if it raises them for all policies like the one the agent was selling.

The Aetna agent in Virginia also assured our reporter that the premiums would not increase. "Once these premiums are set, you'll be paying them forever." He even double-checked his sales manual. "No, they shouldn't go up," he repeated. The sales literature he gave to our reporter didn't say one way or the other, but Aetna's policy is similar to the one from Bankers Life and Casualty. Both companies can raise rates for everyone who owns the same policy in the state.

The Mutual of Omaha salesman was thoroughly confused. His policy is not guaranteed renewable, but he replied, "It is and it isn't. If the state does not permit the company to renew, then we have to pull the policy." While that statement is true enough, it has nothing to do with the renewability feature of his policy.

Mutual of Omaha's sales brochure revealed that the company could refuse to renew a policy, if it refuses to renew them for all those who own that particular policy in the same geographic area of the policyholder's state.

Which one is best?

Naturally, each agent declared his policy the best. The feature they all cited as evidence was the length of time benefits would be paid—unquestionably important, but not necessarily the only measure of superiority.

The Gerber salesman touted his policy as the best because he said it paid benefits for "eight continuous years." And he knocked the American Progressive policy. But as you can see from the Ratings, the Gerber policy was hardly the best, ranking near the bottom. The American Progressive policy ranked close to the top.

What's best is a combination of features. To help you figure out which policy is best, ask for answers to all the questions listed in the box on page 302.

If you get answers that are vague or that contradict the sales literature, ask for a specimen policy. The policy will tell you exactly what's covered and what's not, setting out all the limitations you need to know about.

An agent might be reluctant to give you a specimen policy, however. When our reporter asked the Mutual of Omaha salesman for one, he refused to supply it. If that happens, write to the company. If a company doesn't give you what you need, go to one that does.

Policies usually pay home-care benefits until the regular benefit period maximum has run out. But we found policies that paid home-care benefits for other periods: 30 days, 90 days, one year, two years, or even three years.

Inflation adjustments. The greatest danger facing policyholders is the lack of inflation protection. The $40, $75, or even $100 daily benefit paid by policies today may be woefully inadequate if you need nursing-home care 5 or 10 years from now.

Only one company, Great Republic, sells a policy with built-in inflation protection. The benefit automatically increases by 5 percent each year for as long as a policyholder hangs on to the policy.

Other companies allow policyholders to buy a rider that automatically raises benefits by some amount each year, usually 5 percent. These automatic increases usually stop after 10 years. The riders generally add between 15 and 40 percent to the premium, depending on the coverage.

A few policies pay benefits based on the actual nursing-home charges. If these charges go up, then the benefits will rise as well.

Waiver of premium. Many insurers relieve policyholders of paying further premiums once they've been in a nursing home for a period of time, usually 90 days. This feature is often part of the basic policy, but occasionally policyholders will have to pay extra for it.

Assistance in finding care. A few sellers employ care coordinators who help people find facilities that are covered by their policies. Other companies have toll-free telephone numbers that policyholders or their families can call to find out about nursing homes in their areas.

Will the price go up?

As with life insurance, the older you are when you buy the policy, the more expensive it is. A 75-year-old buying Great Republic's long-term-care policy will pay $3143 a year. A 55-year-old can buy the same policy for $611 a year.

In most cases, the premiums remain "level"—they don't increase after someone buys the policy. (Premiums that do increase annually or every few years as the policyholder grows older make a policy far less desirable.)

But a level premium is not necessarily as level as it looks. A company can increase a so-called level premium on your policy provided it also increases the premium for everyone else in your state who bought the same policy.

One CONSUMER REPORTS reader wrote us about his experience with a policy from Massachusetts Indemnity and Life: The

Continued on page 308

Guide to the Ratings

Listed in order of estimated overall quality. Within red rules, plans were judged approximately equal in quality.

① **Premium.** Premium paid at age 65, expressed as a monthly amount for the purposes of the Ratings.

② **Daily benefit.** The amount of money a policy pays for each day spent in a covered care facility.

③ **Waiting period.** The number of days a policyholder must be in a facility before coverage actually begins.

④ **Each period.** The number of days a policy pays for one stay in a nursing home. Some policies have dollar maximums instead.

⑤ **All periods.** The number of days a policy pays for all nursing-home stays.

⑥ **Skilled.** Policy pays benefits for care in a skilled-nursing facility.

⑦ **Intermediate.** Policy pays benefits for care in an intermediate-nursing facility.

⑧ **Custodial.** Policy pays benefits for care in a custodial-nursing facility. Care is usually limited to helping people perform routine activities.

Ratings

Nursing-home insurance

Company name	① Premium	② Daily benefit	③ Waiting period
Great Republic with Skilled Care at Home Rider 206-285-1422	$ 87.50 [1]	$ 80	20
John Hancock Mutual Life Protectcare - individual 617-421-6000	76.52 [1]	100	20
American Progressive Life & Health 800-243-9214	57.24	80	20
Bankers Life and Casualty with Home Health Care Benefit Rider 312-777-7000	53.54	50	20
Bankers Multiple Line with Home Health Care Benefit Rider 312-777-7000	53.54	50	20
Certified Life with Home Health Care Benefit Rider312-777-7000	53.54	50	20
Union Bankers with Home Health Care Benefit Rider312-777-7000	53.54	50	20
Equitable Life and Casualty 800-453-3245	52.56	60	30
Life Insurance Co. of Connecticut 800-645-9876	68.04	80	20
Metropolitan Life Group Policy for Williamsburg Landing 212-578-2211	95.00 [2]	46 [4]	60
Farwest American Assurance Co. 503-224-7740	50.67	80	20
Bankers Life and Casualty without Home Health Care Benefit Rider 312-777-7000	36.30	50	20
Bankers Multiple Line without Home Health Care Benefit Rider 312-777-7000	36.30	50	20

[1] *Represents one-twelfth of company's annual premium. Monthly premium, if available, would probably be higher.*

[2] *Composite rate means the company charges the same premium at all ages.*

[3] *Represents weekly premium.*

[4] *Benefit paid for one person; policy pays $60 for first spouse of a couple living together.*

[5] *Pays 80 percent of actual charge with maximum policy payment of $80 a day.*

[6] *Pays 100 percent of actual cost.*

[7] *Pays for "usual and customary" charges up to a maximum of $50.*

[8] *Pays 100 percent of "eligible" charges up to a maximum of $75.*

[9] *Pays this for skilled care, pays $50 for intermediate care and $25 for custodial care.*

[10] *Pays 75 percent of charges based on negotiated rates with participating provider.*

[11] *Daily equivalent of company's $2000 a month benefit.*

[12] *Pays half benefits for first 50 days, but waiting period does not apply.*

[13] *Pays for custodial care only.*

[14] *Depends on company's interpretation.*

[15] *Shorter benefit period.*

[16] *Reduced daily benefit.*

[17] *Only after 14 days skilled-nursing care.*

company can usually cancel the policy if it cancels all other policies of that type in a state.

⑨ **Home care.** Policy pays benefits for care at home.

⑩ **No prior hospitalization.** Most policies require a hospital stay of at least three days before entering a nursing home. Policyholder must also enter nursing home within 30 days of hospital discharge. A — indicates the policy has a prior-hospitalization rule. Variations of this rule are listed under advantages and disadvantages.

⑪ **Alzheimer's coverage.** The policy language specifies that Alzheimer's disease is covered.

⑫ **Inflation adjustment.** An optional rider or other arrangement which increases benefits by a set percentage each year for a certain number of years.

⑬ **Preexisting conditions.** Policy covers care for preexisting conditions—ailments or illnesses a policyholder has at the time a policy is issued.

⑭ **Level premiums.** A premium that doesn't increase with the age of a policyholder is highly desirable.

⑮ **Guaranteed renewable.** Company will always renew coverage each time the premium is paid. Without this protection, a

⑯ **Waiver of premium.** Feature allows policyholders to stop paying premiums once they've been in a nursing home for a certain period, usually 90 days.

⑰ **Rejection rate.** The percentage of applicants rejected by a company. A — indicates company provided no information.

⑱ **Substandard risks.** Someone who has health problems can buy insurance with a higher premium, **P**, or a waiver, **W**, that excludes coverage for those problems. Waivers are undesirable.

Maximum benefit		Type of facility														
Each period	All periods	Skilled	Intermediate	Custodial	⑨ Home care	⑩ No prior hospitalization	⑪ Alzheimer's coverage	⑫ Inflation adjustment	⑬ Preexisting conditions	⑭ Level premiums	⑮ Guaranteed renewable	⑯ Waiver of premium	⑰ Rejection rate	⑱ Substandard risks	Advantages	Disadvantages
unlimited	unlimited	[13]	✓	✓	✓	—	—	✓	—	✓	✓	✓	10%	—	B,E	l
2190	2190	✓	[14]	[17]	✓	✓	✓	✓	—	✓	✓	✓	20-25	—	A,C	—
1095	1825	✓	✓	[16]	✓	—	—	—	—	✓	✓	✓	5	—	—	—
1095	unlimited	✓	✓	✓	✓	—	✓	✓	—	✓	✓	✓	10	—	—	—
1095	unlimited	✓	✓	✓	✓	—	✓	✓	—	✓	✓	✓	10	—	—	—
1095	unlimited	✓	✓	✓	✓	—	✓	✓	—	✓	✓	✓	10	—	—	—
1095	unlimited	✓	✓	✓	✓	—	✓	✓	—	✓	✓	✓	3	—	—	—
3650	$250,000	✓	✓	[16]	✓	—	—	—	—	✓	✓	✓	7	—	—	l
1095	1825	✓	✓	[16]	✓	—	—	—	—	✓	✓	✓	5	—	—	l
unlimited	unlimited	✓	✓	✓	✓	✓	✓	✓	—	✓	—	—	10	P	D,F	b,e,h
1460	2190	✓	✓	[16]	✓	✓	✓	✓	—	✓	✓	✓	12	—	A	—
1095	unlimited	✓	✓	✓	—	—	✓	✓	—	✓	✓	✓	10	—	—	—
1095	unlimited	✓	✓	✓	—	—	✓	✓	—	✓	✓	✓	10	—	—	—

[16] *Benefits paid only after pre-confinement in skilled or intermediate facility; benefits are reduced and paid over a shorter period.*

Key to Advantages

- *A* – No prior hospitalization required; company does not arbitrarily decide whether policyholder requires nursing-home care.
- *B* – Built-in inflation adjustment.
- *C* – Toll-free number available to policyholders needing help with nursing-home selection.
- *D* – Care coordinator available to help policyholders find nursing homes.
- *E* – Intermediate or custodial care must follow either hospital confinement of two days or skilled confinement of 10 days.
- *F* – Benefit represents 100 percent of incremental cost for retirement-home resident.
- *G* – Product operates according to HMO service-provided principles.
- *H* – Will verify that institution complies with group certificate language as a covered facility.
- *I* – Must check into nursing home within 90 days of discharge from hospital.
- *J* – Company has large variety of home-care coverages available in separate policy or rider.

Key to Disadvantages

- a – Policyholder must check into nursing home within 14 days of discharge from a hospital—a very short time for decisions.
- b – Company arbitrarily decides whether policyholder requires nursing-home care.
- c – Has premiums that go up annually as policyholder gets older.
- d – Has premiums that go up every few years.
- e – Conditionally renewable, or group insurance contract.
- f – Must remain in retirement community group to keep coverage.
- g – Pays for custodial care that takes place in a skilled or intermediate facility.
- h – Intermediate facilities and custodial facilities (Personal Care Homes) must be on site and owned by retirement community.
- i – Pays only if the facility qualifies, irrespective of level of care.
- j – Pays for intermediate or custodial care that takes place only in a skilled facility.
- k – Pays for skilled, intermediate, or custodial nursing care only in a skilled facility.
- l – Company has Best's rating of B or lower, or is not assigned by Best's.

Ratings of Nursing-home Insurance

Continued

Company name	① Premium	② Daily benefit	③ Waiting period	Maximum benefit ④ Each period	Maximum benefit ⑤ All periods	⑥ Skilled	⑦ Intermediate
Certified Life without Home Health Care Benefit Rider 312-777-7000	$ 36.30	$50	20	1095	unlimited	✓	✓
Union Bankers without Home Health Care Benefit Rider 312-777-7000	36.30	50	20	1095	unlimited	✓	✓
John Hancock Mutual Life Flex Plan 86 - Group Policy 617-421-6000	16.11 [3]	[5]	90	1460	1460	✓	[14]
Group Health Cooperative of Puget Sound Security Care Agreement of Metropolitan Life 212-578-2211	80.00	[6]	30	1460	1460	✓	✓
World Life & Health of Pennsylvania 800-523-1290	53.75 [1]	60	0	730	unlimited	✓	✓
Transport Life 817-390-8000	89.56	80	0	1460	$204,400	✓	✓
AMEX Life 415-492-7000	33.00 [1]	55	20	1460	1460	✓	✓
Aetna Life and Annuity Long Term Care Plan 203-273-0123	33.02	50	20	1460	1460	✓	✓
Reserve Life 214-670-0700	37.32	60	100	1095	1095	✓	✓
Acceleration Life 614-764-7000	83.16	80	100	1825	1825	✓	✓
MidAmerica Mutual Life with Prior Hospitalization 612-331-6370	67.20	60	20	$80,000	$80,000	✓	✓
Continental Casualty with Home Health Care Rider 312-822-5000	43.25	60	15	1825	2555	✓	✓
Harvest Life 616-988-7300	44.22	50	20	1095	1825	✓	✓
Mutual Protective 402-391-6900	43.95 [1]	60	20	1095	1460	✓	✓
Continental Casualty without Home Health Care Rider 312-822-5000	36.40	60	15	1825	2555	✓	✓
MidAmerica Mutual Life without Prior Hospitalization 612-331-6370	78.60	60	20	$100,000	$100,000	✓	✓
Prudential, American Association of Retired Persons (available April, 1988) 800-523-5800	56.00	50	90	1095	1095	✓	✓
Federal Home Life 800-253-0856	42.50 [1]	50 [7]	20	1095	1825	✓	✓
Blue Cross of Washington and Alaska 800-231-9519	69.56 [1]	75 [8]	20	2190	2190	✓	✓
AIG Life Group Long Term Care Certificate with Extended Home Care Rider 302-594-2000	68.20	60	20	1825	1825	✓	—
American Travellers Life without Supplemental Home Health Care Policy 215-343-1000	24.30	50	0	730	730	✓	[15]
NN Investors Life with Home Health Care Rider 800-338-0257	37.80	60	20	1000	1500	✓	✓
Columbia Life 717-784-2716	42.50	50	20	1460	1460	✓	[15]
Travelers Long Term Care Plan Trust 203-277-0111	66.75	50	90	$75,000	$75,000	✓	✓
American Republic with Home Health Care Benefit 515-245-2000	66.42	60	60	$90,000	$90,000	✓	✓
NN Investors Life without Home Health Care Rider 800-338-0257	29.16	60	20	1000	1500	✓	✓
Penn Treaty Life with Supplemental Coverage for Home Health Care 800-222-3469	75.19	50	0	730	730	✓	✓
Prudential, American Association of Retired Persons (Previous Plan) 800-523-5800	48.75	50	90	1095	1095	✓	✓
American Republic without Home Health Care Benefit 515-245-2000	58.44	60	60	$90,000	$90,000	✓	✓
Colonial Penn Life 800-523-4000	55.15 [1]	60	20	1095	unlimited	✓	✓
Gerber Life 914-761-4404	39.50	75 [9]	100	1825	$187,500	✓	[13] [16]
Finger Lakes Long Term Care, Subsidiary of Blue Cross and Blue Shield of Rochester 716-454-1700	102.56	[10]	100	1825	1825	[12]	[13]
American Sun Life with Home Convalescent Policy 800-647-3111	56.81	60	0	1095	unlimited	✓	—
United General Life with Home Convalescent Care Coverage 813-544-8881	39.83 [1]	60	0	730	unlimited	✓	—
Pilgrim Life Three Diamond Plan with Home Private Duty Nursing Benefit of $100 per day 215-534-8800	65.19	67 [11]	0	730	730	✓	✓
Penn Treaty Life without Supplemental Insurance Coverage for Home Health Care 800-222-3469	52.24	50	0	730	730	✓	✓
American Sun Life without Home Convalescent Policy 800-647-3111	31.32	60	0	1095	unlimited	✓	—
Pilgrim Life Three Diamond Plan without at-Home Private Duty Nursing 215-534-8800	52.20	67 [11]	0	730	730	✓	✓
Life and Health of America 215-967-1246	100.00	40	20	730	730	✓	✓
United General Life without Home Convalescent Care Coverage 813-544-8881	28.08 [1]	60	0	730	unlimited	✓	—

Type of facility												
Custodial	Home care	No prior hospitalization	Alzheimer's coverage	Inflation adjustment	Preexisting conditions	Level premiums	Guaranteed renewable	Waiver of premium	Rejection rate	Substandard risks	Advantages	Disadvantages
✓	—	—	✓	✓	—	✓	✓	✓	10%	—	—	—
✓	—	—	✓	✓	—	✓	✓	✓	3	—	—	—
✓	✓	✓	✓	✓	—	✓	✓	✓	5-10	—	D	b
✓	✓	✓	✓	✓	✓	✓	—	—	20-30	—	D,G	b,e
✓	✓	—	—	—	—	✓	✓	✓	3	P,W	C	f
✓	✓	—	—	—	—	✓	—	✓	3-5	—	H	e
[illegible]	✓	—	✓	✓	—	✓	✓	✓	10-20	—	C,J	—
[illegible]	✓	—	—	✓	—	✓	✓	✓	10	—	C	—
[illegible]	✓	—	—	—	—	✓	✓	✓	6	—	—	—
✓	✓	—	—	—	—	✓	—	✓	3	W	—	e
✓	✓	—	✓	—	—	—	✓	✓	—	—	—	c
—	✓	—	—	✓	—	✓	✓	✓	15	P	—	g
✓	✓	—	—	—	—	✓	—	✓	1	—	—	e
—	✓	✓	✓	—	—	✓	✓	✓	17	P	A,C	g
—	—	—	—	✓	—	✓	✓	✓	15	P	—	g
✓	✓	✓	✓	—	—	—	✓	✓	—	—	A	c
✓	✓	✓	✓	—	—	✓	✓	✓	—	—	A,C	—
✓	✓	—	—	—	—	✓	—	✓	1	—	—	e
✓	✓	✓	—	—	✓	✓	✓	✓	20-22	—	D	b
—	✓	—	✓	—	—	✓	✓	✓	20	—	D	i
[13]	—	—	—	—	—	✓	✓	—	2-4	P	J	a,l
—	✓	—	—	—	—	✓	✓	✓	13	P	C	g
[13]	—	✓	—	—	—	✓	✓	✓	2	P,W	A	i
[14]	✓	✓	✓	—	—	✓	✓	✓	—	—	A,C	g
—	✓	✓	✓	—	—	✓	✓	✓	15	—	A,C	g
—	—	—	—	—	—	✓	✓	✓	13	P	C	g
✓	✓	—	—	—	—	✓	✓	✓	10	P,W	—	a,l
✓	✓	✓	—	—	—	✓	—	✓	6	—	C	e
—	—	✓	✓	—	—	✓	✓	✓	15	—	A,C	g
—	✓	—	—	—	—	✓	✓	✓	2	—	—	g
[illegible]	—	—	—	—	—	✓	✓	—	—	—	—	a
[13]	✓	✓	✓	✓	—	✓	✓	✓	30	—	D	b
—	✓	—	—	—	—	—	—	✓	—	—	—	d,e,k,l
—	✓	—	—	—	—	—	—	✓	10 or less	—	—	c,e,j,l
✓	✓	—	—	—	—	✓	—	—	1	P	—	e,l
✓	—	—	—	—	—	✓	✓	✓	10	P,W	—	a,l
—	—	—	—	—	—	—	—	✓	—	—	—	d,e,k,l
✓	—	—	—	—	—	✓	—	—	1	P	—	e,i
✓	—	—	—	—	—	✓	✓	—	2	—	—	a
—	—	—	—	—	—	—	—	✓	10 or less	—	—	c,e,j,l

Key to Advantages

- *A* – No prior hospitalization required; company does not arbitrarily decide whether policyholder requires nursing-home care.
- *B* – Built-in inflation adjustment.
- *C* – Toll-free number available to policyholders needing help with nursing-home selection.
- *D* – Care coordinator available to help policyholders find nursing homes.
- *E* – Intermediate or custodial care must follow either hospital confinement of two days or skilled confinement of 10 days.
- *F* – Benefit represents 100 percent of incremental cost for retirement-home resident.
- *G* – Product operates according to HMO service-provided principles.
- *H* – Will verify that institution complies with group certificate language as a covered facility.
- *I* – Must check into nursing home within 90 days of discharge from hospital.
- *J* – Company has large variety of home-care coverages available in separate policy or rider.

Key to Disadvantages

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- d – Has premiums that go up every few years.
- e – Conditionally renewable, or group insurance contract.
- f – Must remain in retirement community group to keep coverage.
- g – Pays for custodial care that takes place in a skilled or intermediate facility.
- h – Intermediate facilities and custodial facilities (Personal Care Homes) must be on site and owned by retirement community.
- i – Pays only if the facility qualifies, irrespective of level of care.
- j – Pays for intermediate or custodial care that takes place only in a skilled facility.
- k – Pays for skilled, intermediate, or custodial nursing care only in a skilled facility.
- l – Company has Best's rating of B or lower, or is not assigned by Best's.

[1] *Represents one-twelfth of company's annual premium. Monthly premium, if available, would probably be higher.*

[2] *Composite rate means the company charges the same premium at all ages.*

[3] *Represents weekly premium.*

[4] *Benefit paid for one person; policy pays $60 for first spouse of a couple living together.*

[5] *Pays 80 percent of actual charge with maximum policy payment of $80 a day.*

[6] *Pays 100 percent of actual cost.*

[7] *Pays for "usual and customary" charges up to a maximum of $50.*

[8] *Pays 100 percent of "eligible" charges up to a maximum of $75.*

[9] *Pays this for skilled care, pays $50 for intermediate care and $25 for custodial care.*

[10] *Pays 75 percent of charges based on negotiated rates with participating provider.*

[11] *Daily equivalent of company's $2000 a month benefit.*

[12] *Pays half benefits for first 50 days, but waiting period does not apply.*

[13] *Pays for custodial care only.*

[14] *Depends on company's interpretation.*

[15] *Shorter benefit period.*

[16] *Reduced daily benefit.*

[17] *Only after 14 days skilled-nursing care.*

[18] *Benefits paid only after pre-confinement in skilled or intermediate facility; benefits are reduced and paid over a shorter period.*

Reprints of this report are available in bulk quantity. For information and prices, write: CU/Reprints, P.O. Box CS 2010-A, Mount Vernon, N.Y. 10551.

Insurance regulators look the other way

Every state has a department of insurance that's supposed to protect consumers by regulating the insurance policies sold in that state and by supervising the activities of insurance companies. But with few exceptions, regulators are reluctant to look too closely at long-term-care insurance policies, for fear that insurance companies will refuse to provide any coverage at all rather than tailor coverage to meet stern regulatory requirements.

"We are treating long-term care differently than other lines of insurance," says Fred Bodner, chief of the New York Insurance Department's Health and Life Policy Bureau. "We're not going to approve a policy if it's a rip-off, but we're not going to turn it down if it isn't wonderful."

The National Association of Insurance Commissioners (NAIC), which writes model laws for all states to adopt, has written one for long-term-care policies. So far, 11 states have adopted this model, and companies selling policies in these states must comply with its provisions.

States in which insurance policies must meet the NAIC standards are: Arizona, Hawaii, Indiana, Iowa, Kansas, Nebraska, North Carolina, North Dakota, Oklahoma, Oregon, and Virginia. Wyoming and Georgia were about to adopt the model law as we went to press.

The model has some good rules. Waivers denying coverage for specified health conditions are prohibited, and companies cannot offer substantially greater benefits for skilled nursing care than for custodial and intermediate care. Policies must also be guaranteed renewable, but state insurance commissioners may allow cancellation in limited circumstances.

The NAIC model permits other features we consider undesirable: Companies can require a hospital stay before providing benefits for nursing-home care, and can require that a policyholder receive skilled care before qualifying for intermediate, custodial, or home-care benefits. Although the NAIC model prohibits companies from excluding coverage for Alzheimer's disease, it doesn't require policies to specifically spell out that the disease is covered.

Not addressed by the NAIC model law is the need for standard language for long-term-care policies, much like the standard language found in a homeowners policy. Without it, consumers will be forced to rely on confused agents and equally confusing sales brochures.

When CU asked all 50 state-insurance commissioners what complaints had developed from the sale of long-term-care insurance, we learned that consumers complained most often about the unanticipated limitations on the coverage provided by their policies. Consumers believed that their policies covered them for a particular kind of care when, in fact, no such coverage existed.

Members of the NAIC advisory committee that wrote the model law considered requiring companies selling long-term-care policies to include the telephone number of the state-insurance department on forms given to policyholders who are thinking about replacing their policies. That way consumers could call their state regulators if they couldn't decipher a policy. But the committee scrapped the idea when insurance companies argued it would not provide a substantial benefit to consumers.

If insurance regulators don't help buyers of long-term-care policies, who will?

The average length of stay in a nursing home is

456 days

premium for his long-term-care policy had jumped a whopping 150 percent, from $180 to $450, in a single year.

Long-term-care policies don't have much of a history. As a result, insurance-company actuaries may be unable to predict nursing-home use or future costs accurately. Some insurance companies may be pricing their policies too low to cover the promised benefits in the future.

Are you insurable?

Someone who's sick and ready to check into a nursing home can't buy a policy from most companies. Many insurance companies have instructed their agents to weed out "undesirables" before applications reach the home office. If an agent sees that a person can't get out of bed alone or learns that a person has osteoporosis or Alzheimer's disease, the agent won't even deliver a sales pitch. An Aetna agent in Virginia told our reporter that she had to come to his office to hear the sales presentation, probably to see whether she could actually walk.

People who are turned down for life or health insurance might nevertheless be good risks for long-term-care insurance. "Someone with terminal cancer may be a better risk than someone with mild arthritis," says Karl Michaelson, director of health-products underwriting for Aetna. "We do not like to insure people who need aids in getting around—like walkers, canes, and oxygen."

Some companies are choosier than others. Rejection rates vary from 1 percent for Harvest Life, Pilgrim Life, and Federal Home Life to 30 percent for Finger Lakes Blue Cross/Blue Shield.

Many companies offer coverage to people with less-than-perfect health by applying "waivers," which exclude coverage for certain conditions. But buying a policy with a waiver for an illness that's likely to land you in a nursing home is a waste of money.

Instead of waivers, some companies offer coverage at higher rates to people who have health problems. Depending on the severity of the illness or condition, a "substandard risk" could pay as much as 100 percent more than a person whose health qualified him or her for the company's standard rate.

Evaluating the policies

We requested data from 81 insurance companies that sell long-term-care policies or that will start to offer them in the near future. Some told us they were withdrawing their policies and wouldn't have new ones ready in time for us to evaluate. Several companies, including Mutual of Omaha, United American, Combined American Life Insurance Co., American Integrity, National States Life, and Central

States Health and Life, declined to provide the information we requested. (We obtained policies and rate information on some of those companies from state insurance departments, but decided not to include these policies in the Ratings, because the data are incomplete.)

We've listed several policies twice, once with their home-care provisions and once without them. We've included two policies sold by MidAmerica Mutual Life, as well as both the old and new policies underwritten by Prudential for the American Association of Retired Persons.

The Ratings show the plans based on the daily benefit amounts and waiting periods that companies said were selected most often by their customers. If a company didn't tell us which of its plans was most popular, we chose one.

Some of the policies are group policies that have the same characteristics as individual policies. Policies sold by AARP are an example.

To rank the policies, we paid special attention to six main features that contribute to a policy's overall quality: nursing-facility coverage, home-care benefits, restrictions, renewability, relationship of benefits to premium and other aspects of pricing, and underwriting (the process of selecting applicants for coverage). We assigned the most points for quality of coverage and absence of restrictions. We also give bonus points to policies with liberal home-care provisions.

We also examined each company's financial stability, as judged by the A.M. Best Co., which rates insurance companies from A+ (superior) to C (fair). If a company's Best's rating is B or poorer (or if the company is not assigned a rating), we've considered it a disadvantage, since a low rating suggests some risk the company may not be around to pay future benefits.

Should you buy?

We don't recommend long-term-care policies for anyone under age 60 unless the policy offers a good way to keep benefits current with inflation in nursing-home costs. For those over age 60, a policy from one of the top-rated companies might be a reasonable choice. People whose income and assets are fairly modest should not buy long-term care policies. They would quickly qualify for Medicaid benefits should they need to stay in a nursing home.

The best policies cover care in all three types of nursing facility and offer generous daily benefits and benefit periods. They also have a good price in relation to those benefits.

Even the best policies had minor deficiencies in their coverage, however. For example, the Great Republic policy has a generous $80 benefit, paid for an unlimited period. But the policy restricts the benefit to a lower amount for the first 50 days of skilled care. It compensates for that restriction somewhat by not requiring a waiting period before paying benefits. And it is the only policy with a built-in inflation adjustment, a highly desirable feature.

The John Hancock policy offers a generous $100 benefit for six years, a period that should cover most nursing home stays, and its coverage has only a few minor limitations. Buying the policy could be a problem, however. The company estimates its rejection rate at 20 to 25 percent. A company spokesperson says that this rejection rate could drop as John Hancock agents acquire more experience selling the policy.

The most popular policies sold by Bankers Life and Casualty and its subsidiaries, Bankers Multiple Line, Certified Life, and Union Bankers, offer coverage for care in all three types of facility, and the policy specifically says Alzheimer's disease is covered. But these policies ranked somewhat below the top companies because of their relatively low daily benefit ($50), which is available for only three years for each nursing home stay.

A high premium doesn't always buy higher-quality benefits. For example, compare the American Progressive Life policy with the Life and Health of America policy, which ranked next to last.

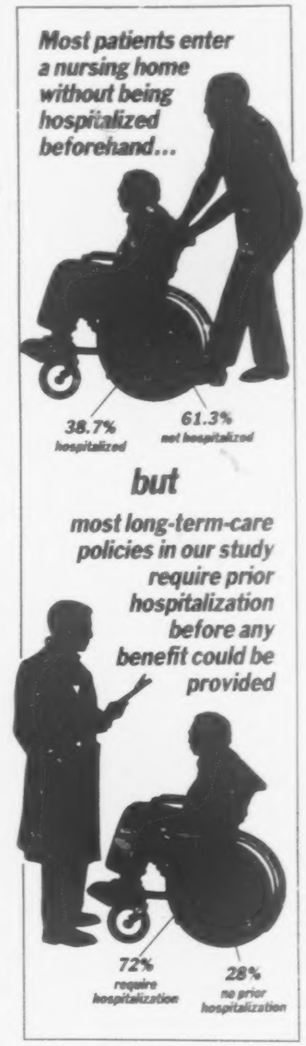
The former provides an $80 daily benefit for a monthly premium of $57.24. The policy offers benefits for three years for one nursing-home stay and five years for all stays. The Life and Health policy offers a skimpy $40 daily benefit (for only two years) yet commands a $100 premium.

Buying a policy through a group doesn't necessarily mean you'll get more for your money. Neither the policy recently sold through the American Association of Retired Persons nor the policy that will replace it this spring ranked highly. They impose a 90-day waiting period before nursing-home benefits begin and pay benefits for only three years. (Visits by home-health-care workers count toward satisfying the 90-day waiting period.) Neither policy, however, requires a stay in a hospital before benefits start.

The old AARP policy has no provision to continue coverage if the group contract is cancelled; the new one does. An AARP spokesperson says that people who have bought the old policy have assurances from AARP that coverage won't end.

Insurance companies have come up with some innovative ideas. For example, Metropolitan's Security Care Agreement for Group Health Cooperative of Puget Sound provides service in accordance with the principles of a health maintenance organization. Patients receive service instead of dollar benefits. Since the benefits offered by this plan will cover 100 percent of the actual cost of nursing-home care, they should hold up well against inflation.

This plan did have its drawbacks. It paid benefits for a relatively short time (4 years), lacked a waiver of premium, and had a high estimated rejection rate (20 to 30 percent).



Must you die poor?

Mary Ann Mattingly, of Indianapolis, looked forward to a comfortable old age when her husband James retired from his job as a security guard at the Eli Lilly Co. The Mattinglys lived reasonably well on the $744 a month he received from his company pension plan and from Social Security. They even managed to dine out on occasion.

But James's health slowly began to deteriorate. He became confused. He could no longer walk. He needed someone to help him eat. In 1979, at the age of 72, he checked into the Eastside Health Care Center, an Indianapolis nursing home. By the time James died in 1986, the Mattingly family, despite a lifetime of work and the security of a pension, had sunk into poverty. It was either that or do without the care James needed in his final years.

James's first year in the nursing home cost $12,000—about $3000 a year more than the family's total annual income. Mary Ann applied for help from Medicaid, the Federal and state program that helps the poor pay their health-care bills. She learned she was too rich for Indiana's Medicaid program. The Mattinglys had accumulated $5000 of Eli Lilly stock, $3000 in a passbook savings account, $2000 in life-insurance cash value, $5000 in a certificate of deposit, and $300 in a Christmas-club savings plan.

The only way Mary Ann could keep James in a nursing home was to become impoverished. Medicaid pays the bills only after the family assets and income run out. That usually doesn't take long. On average, 13 weeks elapse from the time a patient is admitted to a nursing home until the spouse left at home is impoverished. It took Mary Ann Mattingly only nine months to spend on nursing-home care most of what the family had accumulated. When she was poor enough, Medicaid stepped in.

Each state has its own Medicaid rules. Indiana allowed Mary Ann to keep $2250 of her family's assets plus her household furnishings. (If she'd owned a home, she could have kept that, too.) But nursing-home care still took $477 a month of the Mattinglys' $744 monthly income, leaving $238 to cover rent, gasoline and insurance for the car, and food, and $29 for James's incidental expenses.

Once she became poor, Mary Ann, who had never taken a hand-out in her life, qualified for food stamps—as much as $75 worth a month, but more often $30 worth. Special Federal funds to help poor people pay for utilities sometimes paid for her heating bills.

The Medicaid rules did give Mary Ann one way to protect her assets and avoid poverty: divorce. After 32 years of marriage, she wouldn't consider it.

"It was horrible," says Mary Ann. "There's still anger in me. Nobody can understand until they've experienced it. A lot of people today don't know what they have in store."

Indeed they may not.

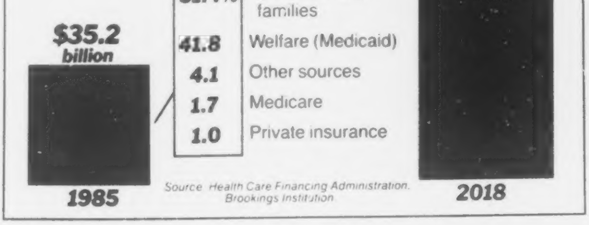
In the year 2030, people over 65 will make up 21 percent of the population, up from 12 percent in 1985. The fastest-growing age group is the "old-old," people 85 and older. Their need for long-term care is greatest.

Nursing-home costs have gone up almost as fast as the age of the population. The average annual cost of a year's stay in a nursing home is now about $22,000, but the cost rises to as much as $45,000 in metropolitan areas such as New York City. Medicaid pays for nearly half of those stays. Federal expenditures for nursing-home care grew tenfold from 1965 to 1980 and will quadruple by 1990.

For years, health economists and social-service planners have seen the shadow of these costs looming. But long-term care for the elderly has only recently won a place on the national agenda—as a seemingly intractable problem for the debt-ridden Federal government, as a giant financial headache for state governments that share the cost of the Medicaid program, as a painful crisis for more and more families, and lately as a marketing opportunity for insurance companies.

What to do?

In 1986, the Secretary of Health and Human Services, Dr. Otis Bowen, issued a report pointing out that Medicare, the health-insurance program for the elderly, did not protect people from the high costs of a catastrophic illness. The report fo-



Who will pay the cost of nursing-home care?

Source: Health Care Financing Administration, Brookings Institution cused attention on the financial consequence of stroke, heart attack, and other medical catastrophes. The reaction to the report spurred Congress to pass bills expanding Medicare to include coverage for catastrophic illnesses of *limited* duration.

But none of the bills do anything to help families pay for long-term care—the greatest source of economic catastrophe. Eighty percent of health-related costs that exceed $2000 a year are due to nursing-home and other long-term-care expenses.

Who then will pay?

The Reagan Administration's answer, echoed by the health-insurance industry: Consumers should buy long-term-care insurance policies, of the type rated in the accompanying report. That set off a small boom in this new insurance product. Unfortunately, few of the insurance policies we looked at adequately meet the need. And the cost of these policies—as much as $1230 a year for a 65-year-old—may well be beyond the means of those who need protection most.

Even those who can afford such policies for themselves or for their parents may find insurers unwilling to sell, usually because the person to be insured is already a candidate for a nursing home. Insurance companies aren't eager to insure people who are almost certain to generate a claim. A few companies in our survey estimated that they turned down as many as 20 or even 30 percent of potential buyers.

Insurance companies would prefer to market their policies to employers, who in turn would offer them to their employees, thus encouraging younger people to buy the insurance when they are still insurable and when the rates are low.

But private insurance for long-term care is a tough sell to employers and employees alike. Employers, some of whom already face huge liabilities for current and former employees' conventional health insurance, are unlikely to pick up the tab for yet another kind of insurance now or in the near future. At most companies that do offer long-term-care insurance, employees must pay the entire premium. But healthy workers either do not know what's ahead for them (estimates are that as many as one of every two people who reach age 65 will eventually land in a nursing home) or prefer not to think about it just yet. When Aetna Life Insurance Co. offered long-term-care coverage to its own employees, only 7 percent bought it. Ten percent of its retirees signed up.

A recent study by the Brookings Institution, using generous assumptions about people's ability to pay for long-term-care policies, predicted that by the year 2018 private insurance would cover only 7 to 12 percent of all nursing-home expenses. Brookings researchers believe that, at best, only one-quarter to one-half of the elderly would buy long-term-care policies.

Thus, for many low- and middle-income families, Medicaid and its prerequisite—spousal impoverishment—will remain the only feasible way to pay for long-term care, unless we find a better way.

Expanding the safety net

Soon the Federal government—and American taxpayers—will have to face the increasingly urgent need for a new social-insurance program that helps chronically ill and disabled people with the costs of long-term care before those costs impoverish them.

The need for universal long-term-care protection can be met through a new mandatory insurance program that complements Medicare and replaces the long-term-care portion of Medicaid. Or the current Medicare program could be expanded to include voluntary insurance paid for by premiums charged to participants.

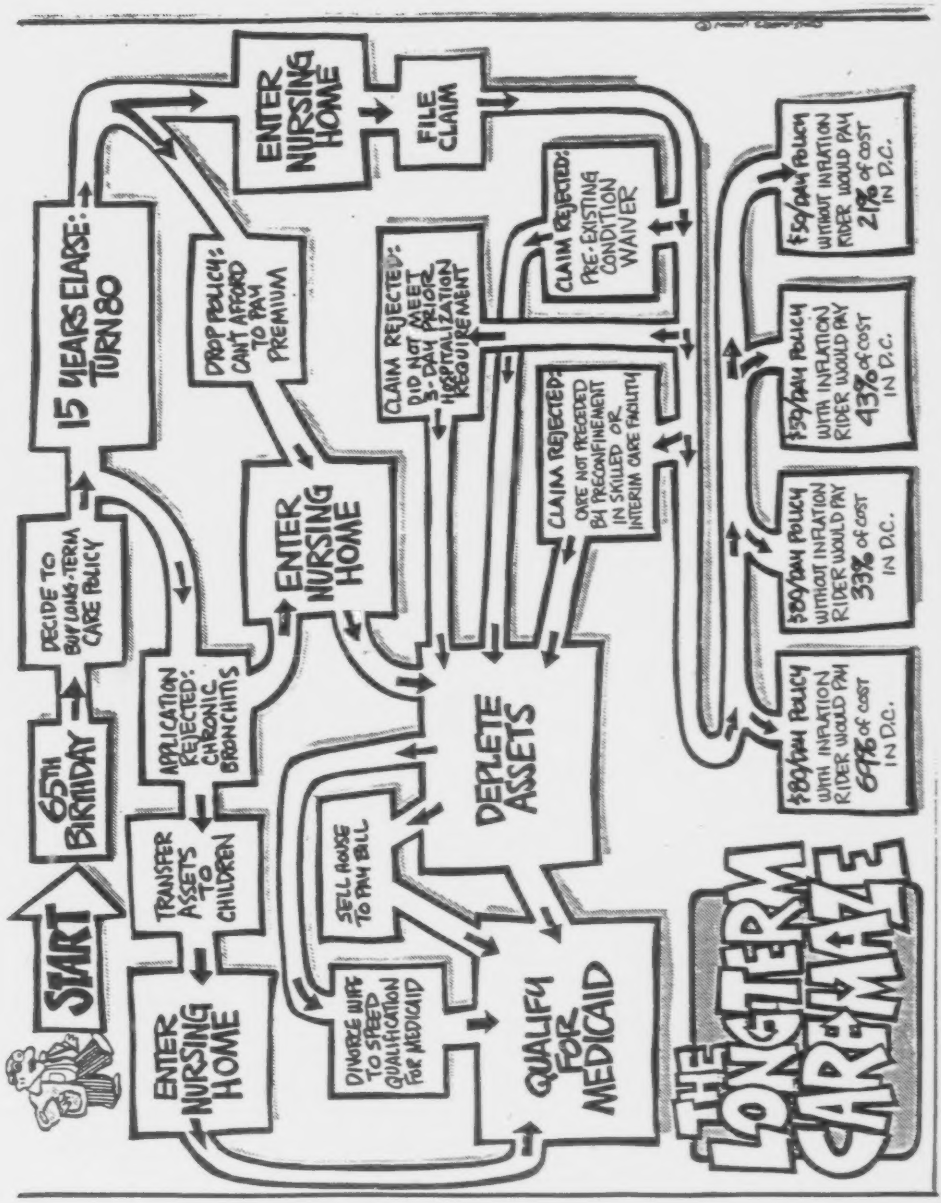
The private insurance system can't spread its costs over a large enough number of people to minimize the financial burden on any one person. Only the Federal government can do that. Funding long-term-care insurance through general revenues spreads the cost among everyone who's a future candidate for long-term care. And making the insurance available to (and required of) everyone eliminates the eligibility standards that now effectively withhold private insurance from those who need it most. A Federally mandated insurance program would also eliminate Medicaid nursing-home coverage, and with it the costs and stigma associated with Medicaid.

So far, however, the only long-term care proposal to surface in Congress addresses long-term care only at home, not in a nursing home. A bill introduced by Claude Pepper, the Democratic Congressman from Florida, would provide a range of home-care, physical-therapy, and homemaker services to the chronically ill elderly and to disabled people of all ages. It would be financed by applying that portion of Social Security taxes that pays for Medicare (1.45 percentage points) to all earned income rather than to the first $45,000 of income, as at present. Some 5 percent of American workers earn more than $45,000 a year; they pay a proportionally smaller tax for Social Security and Medicare than do the great majority of workers who earn $45,000 or less.

Although the Pepper bill, if it passes, may help keep some ill or disabled people out of institutions, it is only a first step toward correcting a health-insurance system that forces too many people into poverty. The bigger step—universal coverage for long-term care no matter where the service is rendered—remains to be taken. ■

What's available now

Program	*Nursing home*	*Home care*
Medicare	Skilled-nursing care covered only in approved facilities: 100% of eligible expenses for 20 days; all but $67.50 a day for next 80 days; nothing after that; no custodial or intermediate care.	Only part-time, intermittent skilled care and speech or physical therapy covered. Person must be confined to home and care-provider must agree to reimbursement under Medicare rules.
Medicaid	Skilled, intermediate, and custodial care covered once a person's assets and income drop below state Medicaid limits.	Part-time nursing and home-health aids provided if requested by physician for those eligible for Medicaid. States have the option to offer a variety of non-medical home-care services.
Medicare supplement policies	Benefits range from nothing to the policy limits for sharing the cost of care for days 21-100; after that, policies pay a set amount each day. Custodial or intermediate care usually not covered.	Usually nothing covered.
Ordinary health insurance policies	Very limited post-hospital, convalescent, skilled-nursing care covered, but usually no custodial or intermediate care.	Very limited post-hospital convalescent care may be covered.
Veterans Administration	Skilled-nursing care provided only in VA facilities on a space-available basis for eligible veterans.	Chronically ill eligible veterans, eligible for medical, nursing, and rehabilitative care.


THE LONG-TERM CARE MAZE
START
65TH BIRTHDAY
DECIDE TO BUY LONG-TERM CARE POLICY
15 YEARS ELAPSE: TURN 80
ENTER NURSING HOME
FILE CLAIM
TRANSFER ASSETS TO CHILDREN
APPLICATION REJECTED: CHRONIC BRONCHITIS
ENTER NURSING HOME
DROP POLICY: CAN'T AFFORD TO PAY PREMIUM
ENTER NURSING HOME
CLAIM REJECTED: DID NOT MEET 3-DAY PRIOR HOSPITALIZATION REQUIREMENT
CLAIM REJECTED: PRE-EXISTING CONDITION WAIVER
CLAIM REJECTED: CARE NOT PRECEDED BY PRECONFINEMENT IN SKILLED OR INTERIM CARE FACILITY
SELL HOUSE TO PAY BILL
DEPLETE ASSETS
DIVORCE WIFE TO SPEED QUALIFICATION FOR MEDICAID
QUALIFY FOR MEDICAID
$80/DAY POLICY WITH INFLATION RIDER WOULD PAY 69% OF COST IN D.C.
$80/DAY POLICY WITHOUT INFLATION RIDER WOULD PAY 33% OF COST IN D.C.
$59/DAY POLICY WITH INFLATION RIDER WOULD PAY 43% OF COST IN D.C.
$59/DAY POLICY WITHOUT INFLATION RIDER WOULD PAY 21% OF COST IN D.C.

Consumers
Union
Publisher of Consumer Reports

July 5, 1988

The Honorable Bob Packwood
United States Senate
SR-259 Russell Senate Office Building
Washington, D.C. 20510-3702

Dear Senator Packwood:

I appreciated the opportunity to testify before the Health Subcommittee at the hearing on long-term care on June 17, 1988. You made several excellent points at the hearing. You are a long-standing friend to consumers, and I wanted to respond to some of the questions you raised.

Medicare Efficiency

As you noted, private markets normally are very effective and efficient at meeting consumer needs. When it comes to health insurance for the elderly, however, the government's record is far superior to that of the private industry. Contrary to popular opinion, the government does a very efficient job of administering the Medicare program. Administrative costs were 1.3 percent for Hospital Insurance (HI) and 4.0 percent for Supplementary Medical Insurance for 1986. Administrative costs for the overall Medicare program (combining costs for both parts of Medicare) are 3 percent. These figures are from 1987 HCFA Statistics, Health Care Financing Administration, Bureau of Data Management and Strategy, September 1987, p. 32. I have enclosed a copy.

In contrast, actuaries project that private long-term care policies will divert 40 percent of the premiums collected to pay administrative costs, marketing costs, and profits. The actual experience could be far worse if the medigap market is any guide.

As I explained in my testimony, Consumers Union believes that these figures have important implications for public policy with regard to long-term care.

Employer Mandated Long-Term Care Insurance

It was clear at the hearing that you recognize that group marketing of private long-term care insurance policies could reduce administrative costs. While employment-based basic health insurance has been a tremendous success, we are not optimistic about the ability to repeat this success with regard to long-term care. In your consideration of the strategy of encouraging group sale of private long-term care insurance, we urge you to explore these issues:

Washington Office
Suite 520, 2001 S Street, Northwest · Washington, D.C. 20009 · (202) 462-6262

1. Should employers be required to pay for long-term care insurance?

Employers face an increased burden due to rising costs of both current employee and retiree health benefits. In addition, it is likely that the solution to the problem of the uninsured will involve an increased employer mandate. At some point, employers will legitimately argue that they have paid more than their share of health benefits.

2. Will employees purchase long-term care insurance policies for themselves if they have to pay a large share of the cost?

To date, employees have been reluctant to enroll in programs for which they must pay the full cost. We don't expect this reluctance to buy a policy to change, and for good reason. Most policies have level premiums by design, fixed at the age of purchase. (Though level by design, companies remain free to raise the premiums, in practice.) Premiums from early years help to finance the risk of needing long-term care that increases with the person's age. Yet, should the policyholder drop the policy, the companies do not refund any money to the consumer. Another question employees have is portability: will they be able to continue the policy if they change jobs? A third reason for employees to resist enrolling is the belief that the government may cover certain long-term care costs by the time the employees would need them. A fourth concern employees might have is getting locked in to what may turn out to be an inadequate long-term care policy, in light of the continuing change of the insurance market.

3. Will employees purchase long-term care insurance policies for their spouse and parents?

The same factors that cause employees to resist purchasing policies for themselves are repeated here. In addition, the cost can get extremely high when older parents (or in-laws) are to be covered. One further point is that while companies may automatically accept all current or newly retired applicants, they underwrite coverage for dependents. Therefore this employment-based coverage will not be available to people with high health risks.

We believe that a key public policy goal should be to design a long-term care financing system that prevents impoverishment of people who need long-term care. Increased estate taxes could be a significant revenue source for such a program. Even employment-based insurance for dependents will be extremely expensive, rendering it available only to the relatively affluent who may view it largely as an "estate protection" plan.

4. When will employment-based insurance yield results?

If the program covers employees (and possibly spouses) only, i.e., people who are most likely to be 65 and under, then the actual use of covered long-term care services is not likely to begin for a number of years, and will not be totally phased in for around 50 years. This strikes Consumers Union as a long time to wait, especially when one considers the fact that many employees are likely to drop out from the system for one reason or another. Again, we believe a social insurance system has the potential to protect everyone -- regardless of age, income, health status or employment status -- without creating a patchwork system of coverage that depends on so many things going right (e.g., financial stability of the insurance company, portability of policies, continued employees' ability to pay the premium).

One public policy option we described in our testimony has the potential to exploit the advantages of a group marketing system without the pitfalls described above. A voluntary Medicare Part C, to cover long-term care costs, could replicate Medicare's efficiency and offer protection against long-term care costs. It could be totally premium financed; the premium could be adjusted to income; and it could be made available to people regardless of health status, with provisions to avoid undue adverse selection.

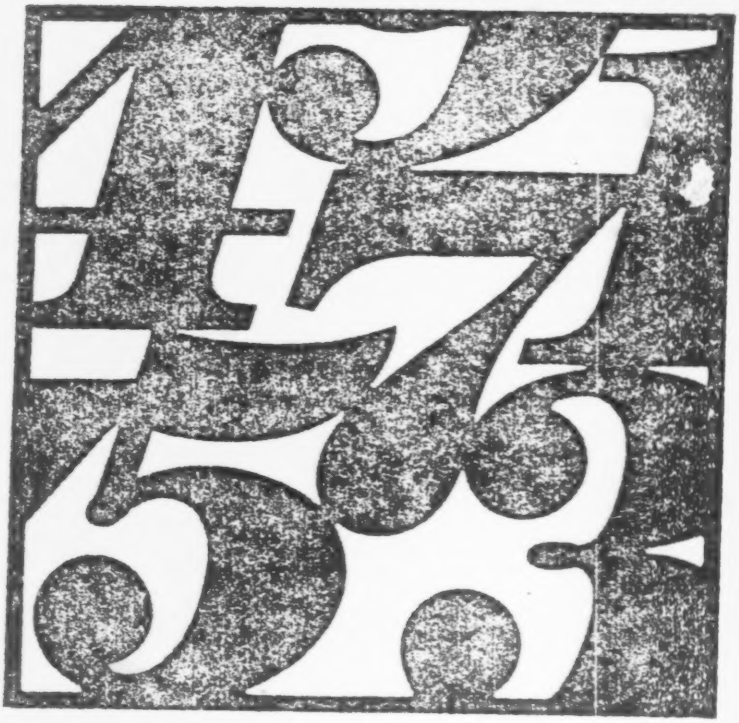
We would be delighted to talk with you or your staff to explore these ideas further.

Sincerely,

Gail Shearer

Gail Shearer
Manager, Policy Analysis

1987 HCFA Statistics



Health Care Financing Administration
Bureau of Data Management and Strategy
September 1987

MEDICARE ADMINISTRATIVE EXPENSES/TRENDS

	Administrative Expenses	
	Amount In Millions	As a Percent of Benefit Payments
HI Trust Fund[1]		
1970	$ 157	3.1
1975	266	2.4
1980	512	2.0
1984	629	1.5
1985	834	1.8
1986	664	1.3
SMI Trust Fund[1]		
1970	237	12.0
1975	462	10.8
1980	610	5.7
1984	891	4.5
1985	933	4.1
1986	1,060	4.0

(Calendar year data)

[1] Hospital insurance (HI); supplementary medical insurance (SMI).

MEDICARE/CONTRACTS

	Part A Intermediaries	Part B Carriers
Blue Cross/Blue Shield	47	27
Other	7	8

(January 1987)

MEDICARE/CLAIMS PROCESSING COSTS

	Net Unit Cost Per Claim		
	1975	1980	1986
Part A Intermediaries	$3.84	$2.96	$1.96
Part B Carriers	2.90	2.33	1.75

(Fiscal year data)

MEDICARE/CLAIMS PROCESSING

	Part A Intermediaries	Part B Carrier
Claims Processed (millions)	65.1	296.4
Total Costs (millions)	$362.4	$618.7
Claims Processing Costs (millions)	$111.3	$481.5
Claims Processing Unit Costs	$ 1.97	$ 1.72
Range:		
High	$ 2.39	$ 1.93
Low	$ 1.65	$ 1.58
Average Processing Time (days)	14.7	18.4

(Fiscal year 1986)

MEDICARE/CLAIMS RECEIVED

	Calendar Year 1986
Intermediary (thousands)	65,251
Percent of Total	
Inpatient Hospital	18.2
Outpatient Hospital	64.0
Home Health Agency	8.3
Skilled Nursing Facility	1.3
Other	8.2
Carrier (thousands)	306,714
Percent of Total	
Assigned	68.0
Unassigned	32.0

TESTIMONY

of the

BLUE CROSS AND BLUE SHIELD ASSOCIATION

by

BERNARD R. TRESNOWSKI
PRESIDENT

Mr. Chairman and Members of the Committee, I am Bernard R. Tresnowski, President of the Blue Cross and Blue Shield Association. The Association is the coordinating organization for the 77 Blue Cross and Blue Shield Plans throughout the nation. Collectively, the Plans provide health benefits protection for more than 80 million Americans.

I am pleased to have the opportunity to testify on S. 2305, the Long-Term Care Assistance Act of 1988. The bill embodies what we believe is the best and only viable approach to a national long term care insurance policy -- the concept of a public and private sector partnership. We are confident that this proposed legislation will serve as a catalyst for the most serious discussion to date of the appropriate roles for both the private sector and the government in providing long term care services.

Very briefly, the following statistics demonstrate the current long term care financing problem:

- Approximately 30 million Americans are over age 65. They comprise over 13 percent of our population, but will grow to over 18 percent, or 55 million, by the year 2030.

- The number of individuals over age 85 -- an age group particularly at risk for needing long term care services -- will grow three to four times as quickly as the general population.

o Individuals and their families pay over half of total nursing home expenses out of their pockets -- over $19 billion in 1986. Medicaid pays for most of the rest, but only after a family has exhausted nearly all financial resources.

Our testimony describes what Blue Cross and Blue Shield Plans are doing about these problems, what we believe the government should do, and how the government can assist development of the private long term care insurance market. We also raise questions that relate to the design of a national long term care policy that will best meet the needs of our aging society.

Blue Cross and Blue Shield Plans Long Term Care Activities

Blue Cross and Blue Shield Plans and the Association have made development of long term care insurance policies one of our highest priorities. Twelve of our Plans are now marketing these products, and two more will be soon offering policies.

Along with care provided in nursing homes, benefit programs cover a wide variety of home and community-based health services, including home health visits, adult day care, homemaker services, medical transportation, and respite care. Respite care is one type of the non-traditional benefits needed by those suffering from chronic conditions. It covers the services of trained personnel who give relief to family caregivers.

These policies generally may be purchased by persons between the ages of 40 and 84. Premiums vary with age at initial purchase and with the benefit options selected. Rates are set at a level that will, over an expected lifetime, accumulate the funds necessary to meet the increasing need for services in later years.

Due to the lack of data on utilization and costs of long term care, most of the industry's early long term care policies were quite restrictive. These policies predominantly offered nursing home coverage and usually required prior hospitalization before individuals could receive these benefits. Alternative levels of care, such as home care or custodial care, were seldom offered.

In contrast, long term care insurance policies developed by Blue Cross and Blue Shield Plans more recently tend to offer benefits that are tailored to meet a variety of long term care needs. For example, several Blue Cross and Blue Shield Plans offer more traditional "service" benefits which base payment on the cost of services received rather than a fixed indemnity amount of so many dollars per day. This type of payment structure assures individuals that their insurance coverage will keep pace with inflation.

Many of our policies provide extensive coverage for home care services and some policies are designed exclusively to provide home care or custodial care. Many policies also include individual case management benefits to help assess a person's needs and to provide care in the most appropriate settings. Some policies also protect against inflation by incorporating features such as annual percentage increases in fixed payment amounts for covered services or periodic opportunities to increase benefit levels.

The Association is developing a program to support Plan entry into this important new market. The Association will make available a benefit design package, administrative support, and a reinsurance option to minimize an individual Plan's risk. We believe this program will speed up entry into the long term care market by: helping Blue Cross and Blue Shield Plans avoid the cost and time of product development; providing administrative efficiencies not usually available with a new product; and reducing the tremendous risk associated with entering the uncharted territory of long term care insurance.

The Government Role in Assuring the Availability of Long Term Care Services

The Blue Cross and Blue Shield Association, with our member Plans, performed extensive market research and actuarial analyses and used this as the base for designing our long term care products for the private market. Using this research, we have developed a number of recommendations for government action that we believe would make private insurance more widely available.

1) Market Incentives. First, we recommend the establishment of incentives for the sale and purchase of long term care insurance. The most important of these incentives is to clarify that long term care insurance products are to

be taxed on the same basis as non-cancellable accident and health insurance. This would permit insurers to accrue reserves for these products on a tax-favored basis. Specifically, insurers should be allowed to set aside a portion of annual premiums collected, and accumulate interest on these funds on a non-taxable basis. Insurers would be allowed to do this until the funds are sufficient actuarially to pay for future liabilities for long term care benefits.

We recommend that insurers be allowed to establish such reserves on a tax-favored basis after the insurance has been in force for one year, instead of the current two-year requirement. Under current law, insurers can not establish tax-favored reserves for most types of health insurance until the insurance policy has been in force for two years.

Allowing tax free reserve build up after one year would help insurers keep premiums as low as possible. We also recommend that long term care insurance be given the same tax-favored status granted to group health benefits. Specifically, benefits paid out, and employer contributions for, long term care insurance would be excluded from an employee's income. Also employers should be permitted to deduct contributions to long term care insurance as a current expense, and to offer such a benefit as part of a cafeteria plan.

Finally, we suggest that individuals be permitted to deduct qualified long term care expenses and premiums using the limited medical expense deduction allowed under Section 213 of the Internal Revenue Code. This section permits individuals to deduct medical expenses in excess of 7.5 percent of their adjusted gross income.

We believe these measures addressed particularly to the group market would provide employers and insurers with new incentives to provide long term care insurance.

2) Continued Regulatory Flexibility. Our second recommendation is for continued regulatory flexibility at all levels of government to support the development of a variety of private sector long term care financing

mechanisms. The Blue Cross and Blue Shield Association and its member Plans participated in the development of the long term care Model Act and Regulations by the National Association of Insurance Commissioners (NAIC). We support this initiative. However, we remain concerned that further steps such as the premature establishment of additional minimum standards or other regulations could inhibit the development of innovative private sector solutions.

These concerns for continued flexibility should not be misinterpreted as disregard for consumer protection. The Blue Cross and Blue Shield Association is, in fact, very concerned that consumers receive realistic protection against the costs of long term care in exchange for their premium dollars. For this reason, in order to qualify for favorable tax treatment, we recommend that insurers would have to meet certain requirements, based on the NAIC Model Act and Regulations. Insurers would, for example, be required to provide coverage for a variety of services for not less than 12 consecutive months. Insurers also would have to offer coverage on a "guaranteed renewable" basis, which would prohibit cancellation of a policy on the basis of a policy holder'sage or deteriorating health. In addition, the Blue Cross and Blue Shield Association supports a requirement that only insurers who are subject to the jurisdiction and regulation of at least one state regulatory agency could receive favorable tax treatment of their policies. This requirement, which goes beyond the recommendations of the NAIC, would enhance consumer protection by ensuring that all issuers be required to meet the regulatory standards of at least one state regulatory agency.

3) Public Education. Third, we support a government role in clarifying for individuals the nature, extent, and risks of significant long term care expenses. Many older people are under the impression that Medicare provides coverage for long term care. We need to increase public understanding that Medicare is designed primarily to cover acute care, and that it does not provide adequate coverage for chronic care or non-acute nursing home care. Public misunderstanding on this issue is clearly a major obstacle to the expansion of needed long term care coverage. The recently approved Medicare

The new program would be financed by removing the wage cap on the FICA payroll tax, increasing the Medicare Part B premiums by $2 a month, increasing the income related Medicare premium as needed, and imposing a 5 percent surtax on inheritances exceeding $200,000.

We strongly support the section of the bill related to clarification of the tax treatment of long term care products. The proposed changes are essential in making private coverage more widely available. We hope to see them enacted in this session even if broad agreement cannot be reached on comprehensive long term care legislation.

There are several major questions that we believe require further exploration in designing a public and private partnership. These questions deal with how scarce federal resources should be used, the most appropriate interface of public and private coverage, and the financing and management of the public program.

How Can We Best Use Scarce Federal Dollars? .In a period of limited federal resources, it is important that federal resources be used only where they are most needed. A key question for debate is whether an entitlement program that provides benefits to everyone after a two year waiting period -- or deductible -- is the best use of public funds. It may well be that greater dependence on private coverage for those who can afford the premiums would make funds more available for those whose needs the private sector cannot meet -- the low income, the old-old uninsured, and those with pre-existing conditions.

To answer these questions there is a need for better data, such as nursing home admission rates and length of stay information, in order to estimate the financial and coverage implications of deductible arrangements for the public and private sectors. We will look forward to continuing work with the committee on these questions.

What are the key elements necessary for an effective interface between public and private long term care programs? Under a universal entitlement program that embodies a waiting period to be filled in by the private sector, predictability of government benefits is essential to assure that the elderly have a continuum of protection.

Long term predictability of government benefits is necessary for consumers to plan for their retirement and to feel comfortable purchasing a private policy which they may not use for many years. Long term predictability is essential also for private insurers to design policies that provide good protection.

We primarily are concerned that, unlike the situation with respect to our Medicare supplemental policies, the government cannot count on the private sector using the same "gap filling" model in response to changes in government long term care coverage. Because the nature of long term care policies dictates that premiums be set as much as twenty years in advance of expected benefit use, our ability to adapt our policies if the government reduces or otherwise changes long term care benefits is limited greatly.

We in the private sector realize that the lack of information related to morbidity, mortality, utilization, and institutional capacity, create inevitable uncertainty as to what benefits the government can or should sustain over time. In addition to these uncertainties, the government faces fiscal pressures separate and apart from the cost of this program which could well create pressures to modify waiting periods or possibly other benefit changes. For example, this could lead to a situation where someone could purchase a two year private policy only to find, when they need benefits, that there is a three year waiting period for government benefits.

This raises a fundamental question of whether the best basis for dividing responsibility between the public and private sectors is a universal government program with significant cost sharing or whether coordination should be based on each sector assuming responsibility for a defined segment of the population.

How can public benefits best be financed and administered? A third area for debate is the best way to finance and administer a new federal long term care insurance program.

catastrophic legislation includes a provision that requires beneficiaries be notified as to of what Medicare will and will not cover. We believe this will be helpful to beneficiaries.

4) Data Collection. Finally, we believe the federal government should continue to encourage the collection and availability of cost and utilization data on long term care services. We are pleased that Blue Cross and Blue Shield organization representatives were included in an HHS Task Force which met last year to study how we should gather and organize data on long term care. These data are critical in order to develop effective and sustainable programs with realistic premiums.

We are confident that, with the needed government support, the private sector can increase significantly the number of people protected against the cost of long term care needs. However, we also know that the private sector can not address the needs of all segments of the population. Individuals already 85 years old, people already suffering from chronic illness, and the low income generally will not be able to enter the private long term care market. We believe that these groups will need to be a primary responsibility of the federal government.

Comments on S. 2305

S. 2305 would promote a public-private approach to long term care protection. The bill would expand Medicare coverage to include nursing home benefits after a two year exclusionary period, home care after an annual deductible and a 20 percent beneficiary co-pay, and respite care up to $1,000.

The proposal also would establish tax incentives to encourage the development of private long term care products. The intent is that private insurance would cover the two year waiting period prior to government benefits becoming effective. The tax incentives would include: classifying long term care products as accident and health insurance for purposes of the tax bill, providing an individual tax deduction for long term care premiums, and allowing employers to provide long term care insurance as part of a cafeteria plan.

We believe that the basic financing concept of S. 2305 -- budget neutrality -- is a sound one. In today's fiscal environment, major new programs need to be matched with the revenues to sustain such commitments. Multi-source revenue bases and earmarked taxes, such as provided by S. 2305, are essential.

We are concerned, however, about the extent of premium financing from elderly persons that may be required by S. 2305. Given the difficulty of estimating current and especially future costs, it is possible that beneficiaries will be financing an even larger proportion of the program than currently anticipated.

Although the proposal is silent on the question of whether the new Part B premium amount would be mandatory or voluntary, there are considerations to either approach. Mandatory Part B premium increases are problematic given the projected expense of Medicare's basic benefits and recently added catastrophic coverage. The supplemental premium for the proposed long term care coverage could lead to a decrease in participation in Part B. On the other hand, a voluntary premium would increase the risk that only those who anticipated using the benefits would participate in the program. If so, the premiums for those participating would be extremely high -- to the point of being unaffordable unless heavily subsidized.

Conclusion

In conclusion, we endorse the basic concept of S. 2305 -- a public-private partnership -- as the most promising approach to developing a much-needed long term care system for protecting the nation's 30 million. We strongly support the tax provisions of S. 2305 and urge that they be adopted at the earliest possible date. We believe that more discussion and analysis is necessary to determine whether those who need long term care are best served by an entitlement program that uses a waiting period/deductible approach or an approach that focuses federal dollars on those who do not have access to private programs. However, I am confident that further joint exploration of this can lead to a public-private partnership. We look forward to continuing discussions and to working with the Committee.

PREPARED STATEMENT OF PAUL WILLGING

Mr. Chairman and Members of the Committee:

I am Paul Willging, Executive Vice President of the American Health Care Association (AHCA), the largest association representing America's long term care providers. As an association that represents over 9,000 nursing homes which provide care for about 950,000 nursing home patients each day, AHCA is pleased to have the opportunity to comment on S. 2305, the Long-Term Care Assistance Act of 1988.

Mr. Chairman, we applaud you for your leadership in developing a public-private sector answer to the difficult question of long term health care. Your series of hearings will bring much needed attention to the failure of current programs to meet long term needs and to the hardships which individuals and families face in the event of needing long term care.

We strongly support your proposal to provide for expanded Medicare coverage of long term care after a long deductible period, at the same time encouraging the development of private long term care insurance. It is clear that the cost of providing more adequately for our elderly's long term care needs is so great that it can not be borne by either the private sector, or the public sector, alone. We feel that your "stop-loss" proposal is a responsible solution that balances individual and family responsibility with appropriate governmental assistance.

I think it is fitting, Mr. Chairman, that you turn Congressional attention to the issue of long term care today, after the recent culmination of the catastrophic conference that focuses solely on protection against acute health care expenses. The so-called catastrophic legislation provides limited benefit at significant expense to Medicare beneficiaries, but leaves the aged exposed to their greatest health care risk -- paying for nursing home care.

From the elderly's perspective, their primary out-of-pocket expense is for long term care, which is more than the combined personal expense of hospital and physician care. In fact, almost 82 percent of out-of-pocket costs for elderly persons who incur catastrophic medical expenses is spent on nursing home care. We hope that enactment of a long term financing plan will be the next giant step that Congress takes to close the last major hole in the elderly's health safety net.

We must begin to make improvements in long term care financing not only for the present, but for the future, as well. Every demographic trend shows that the need for long term care will only increase. Life expectancy has improved so that today's 65 year-olds can expect to reach an average age of 81. By the year 2000, the number of Americans over the age of 85 will have doubled. Although advances in medical science and technology have been successful in prolonging life, there have not been comparable breakthroughs in the chronic disabilities associated with old age. Nursing home utilization among those age 85 and over remains 14 times the rate for those age 65-74. In short, the elderly are not only getting older, but "sicker" with multiple and more debilitating limitations.

The lack of insurance and personal resources will continue to force individuals to risk financial devastation in the event of long term care. Much attention has been given to improvements in the economic status of the elderly, in general. While this development shows the potential for long term care insurance and other private financing arrangements, the improvement is far from uniform, and many will be unable to afford long term care when they need it. Almost by definition, aging is associated with declining financial status due to depleting resources.

Clearly, there is a lack of comprehension on the part of many individuals about the financial risk they run in the event that they need long term care. Unfortunately, most elderly erroneously believe Medicare will pay for nursing home care. However, Medicare coverage is almost totally restricted to acute episodes of care, and private insurance coverage has been extremely limited. Of the nation's nursing home expenses, Medicare covers less than two percent, and private insurance less than one percent.

The reality is that personal savings are the first line of long term care defense. But for most nursing home patients, their savings seldom last as long as the care is needed. For example, it has been projected that about one-half of the approximately 1.2 million elderly persons who will be admitted to nursing homes in 1988 will have out-of-pocket expenses greater than $5,000 for their stay, and over 10 percent will have personal expenditures of over $50,000.

Medicaid, by default, is the major public payor for nursing home expenses as individuals, once institutionalized, exhaust their financial resources. Approximately one-third of our population would be impoverished after only 13 weeks in a nursing home. Two-thirds of our elderly would exhaust their financial resources within the first year of a nursing home stay. Once institutionalized, such individuals seldom return to the community, even if their condition improves, because of lack of personal resources and the difficulty associated with readmitting a Medicaid patient to a nursing home. Medicaid, originally intended to protect the poor, perversely forces impoverishment, thus ensuring dependency on public assistance.

Changes must be made to provide protection for those needing long term care as well as to encourage the elderly to purchase long term care insurance. Your approach, Mr. Chairman, would address both needs. S. 2305 would expand Medicare to cover nursing home care after a two-year deductible, during which the individual is responsible for his or her care. Such an exclusionary period would create strong incentives for individuals to purchase long term care insurance to cover the deductible. Insurance companies would have a defined period of risk -- leading to lower-priced insurance premiums that would be affordable to a greater proportion of the elderly. We feel this bill would provide for appropriate cooperation between the public and private sectors to better address the elderly's long term care needs.

From the perspective of nursing home care providers, there are several other points that we feel should be addressed in any type of long term care financing plan.

Preserve Arena for Private Pay Patient

We have great concerns about other long term care financing proposals, such as Senator Ted Kennedy's "LifeCare" plan, which would provide first-dollar coverage of nursing home care with no deductible or copayment. This concept would result in nearly complete federalization of long term health care, which would drain the federal budget as well as eliminate the legitimate role that the private sector should play in the financing solution. First-dollar coverage would be prohibitively expensive and unnecessary, and would likely create a massive "woodworking" effect that would generate increased utilization -- a particular concern with long term care since the majority of care is provided by families and informal caregivers.

Large segments of our population can -- and should -- provide for their own future needs. The two-year deductible in your proposal, Mr. Chairman, is a reasonable exclusionary period which will provide a needed incentive for individuals to purchase private long term care insurance. Private insurance offers these individuals a promising, but largely untapped, alternative to spending their assets and impoverishing themselves to pay for their long term care needs. As you have pointed out, however, the success of this approach depends on the response of the private long term care industry and its ability to design and market affordable insurance policies.

Appropriate Rate-setting for Providers

We feel that any reimbursement system used for long term care providers must be adequate to ensure that providers can provide quality care. We must avoid the problems inherent in many state Medicaid programs in which nursing home rates are more a function of state budgetary pressures, rather than a reflection of the cost of providing adequate care.

We do have concerns about your reimbursement language, Mr. Chairman, that makes reference to regional "fee schedules" for nursing homes that we feel could imply a flat rate payment system. We strongly support a prospective payment system that recognizes the needs of the patient and the legitimate costs incurred by facilities in providing care. AHCA has been very supportive of prospective payments for nursing home services; we have worked toward expanding prospective reimbursement that is available under current law for certified skilled nursing facilities that provide fewer than 1,500 Medicare patient days. We would urge that language be included in your bill that would direct the Secretary to devise a prospective payment plan, with input from the industry, that would provide for appropriate variations based on patient needs, historical cost structures, and regional wage rates.

Designated Funding Source for LTC Benefits

We support the creation of a separate trust fund that would be created in S. 2305, to be funded by a combination of an increase in Part B premiums, the lifting of the income cap subject to the 1.45 percent Medicare tax, and an increase in estate and inheritance taxes. A sound, designated funding source is critical to avoid the need for future financing from general federal revenues. We recognize that final cost estimates have not been formulated for S. 2305; however, we note your commitment to maintaining budget neutrality. We feel the concept of a payroll tax is in keeping with the notion that this new Medicare expansion should transform our federal long term care financing system to a social insurance program, rather than a welfare program.

Allow Supplementation for Non-covered Services

We also feel that clarification needs to be made in the legislation that individuals may purchase additional services in a nursing facility that may not be covered under the Medicare reimbursement rate. This issue was addressed recently in the nursing home reform legislation included in the Omnibus Reconciliation Act of 1987. The Congress, in its wisdom, explicitly clarified that facilities may charge residents for items and services requested and received that are not covered by the state Medicaid plan. We suggest that similar language be included in S. 2305 that would allow Medicare beneficiaries to purchase additional services over and beyond what the Medicare program may reimburse.

Enhance Consumer Protection in LTC Insurance Market

Although, private long term care insurance has been severely underutilized, it is important to note that in a relatively short period of time the number of insurance companies selling long term care insurance has reached over seventy, and the number of policies in force exceeds one-half million -- double that of just two years ago.

Many state legislatures have been active in ensuring quality long term care insurance products. Seventeen states are considering proposals to establish minimum standards for long term care insurance. Last year, ten states adopted versions of the National Association of Insurance Commissioners' (NAIC) model law, and another nine are expected to do so this year.

In response to research, consumer surveys, provider input and the NAIC recommendations, many insurers have modified their policies and are offering more flexible benefits along the long term care continuum. Restrictions, such as prior hospitalization requirements, are being removed in policies with time and additional market experience. However, we feel that it is important for Congress to avoid the pitfalls of the early days of Medigap insurance development and to work now to protect the purchasers of private long term care insurance from abusive marketing practices. We support legislation promoted by Senator Durenberger to establish a program of voluntary certification of long term care insurance policies which will enhance consumer protection and confidence in this emerging insurance field.

Enact Federal Incentives to Purchase LTC Insurance

Despite progress in the development of private long term care insurance, a number of properly targeted tax clarifications and incentives could accelerate the development of long term care products. These include:

- Allowing the deductibility of insurance reserves and related investment earnings;
- Applying the same tax status to long term care products as now exists for health insurance premiums and benefits;
- Offering tax credits for the purchase of long term care coverage;
- Allowing the inclusion of long term care benefits in "cafeteria" plans; and
- Eliminating the restrictions on the prefunding of retiree health benefits.

Additionally, state Medicaid programs offer significant potential for creativity in the development of long term care partnerships between the public sector and private insurance. Pilot programs to allow states to purchase and design long term care insurance packages for their Medicaid recipients are currently under way in several states, and their outcomes should be carefully studied for more extensive application.

In closing, Mr. Chairman, we salute your foresight in the introduction of your long term care financing proposal. AHCA looks forward to the opportunity to work with the members and staff of the Senate Finance Committee to better address the long term care needs of our elderly.

THE HONORABLE PETE WILSON
UNITED STATES SENATOR (R-CA)

MR. CHAIRMAN,

THANK YOU FOR GRANTING ME THE OPPORTUNITY TO ADDRESS YOUR DISTINGUISHED SUBCOMMITTEE. THIS APRIL, WHEN YOU INTRODUCED S. 2305, I HEARD YOU SAY THAT YOU HOPED TO BEGIN A NATIONAL DIALOGUE ON THE DELIVERY AND FINANCING OF LONG TERM CARE. I WANT TO PARTICIPATE ACTIVELY IN THIS DIALOGUE AND IN THE PROCESS OF REFORMING THE WAY OUR COUNTRY APPROACHES ENSURING ACCESS TO LONG TERM CARE.

THESE HEARINGS, ON YOUR LONG TERM CARE BILL, HAVE ENORMOUS SIGNIFICANCE TO THE WHOLE OF CONGRESS, ESPECIALLY AFTER THE HOUSE VOTE ON THE PEPPER BILL LAST WEEK. DEFEAT OF THE PEPPER BILL CONFIRMS THAT CONGRESS STILL HAS GRAVE RESERVATIONS ABOUT COMMITTING SUBSTANTIAL FEDERAL FUNDS TO FINANCE A FURTHER EXPANSION OF MEDICARE. MOST MEMBERS AGREE THAT CONGRESS CAN FIND VIABLE SOLUTIONS TO THIS PROBLEM WITHOUT IMPOSING WHAT THEY CONSIDER UNREALISTIC NEW EXPENDITURES UPON THE FEDERAL GOVERNMENT OR UPON THOSE WHO PAY FOR MEDICARE COVERAGE.

DESPITE THE HARD, CAREFUL WORK WHICH WENT INTO YOUR BILL AND THE MANY FINE PROVISIONS, I BELIEVE THAT THE COST ALONE WILL MAKE IT UNPASSABLE DURING THIS 100TH CONGRESS. BUT THAT DOES NOT MEAN THAT CONGRESS CANNOT AND WILL NOT PASS SOME TYPE OF MORE TARGETED LONG TERM CARE BILL THIS YEAR AS WE CONTINUE TO WRESTLE WITH THE COMPLEXITIES OF COMPREHENSIVE BILLS SUCH AS YOURS.

EVERYONE IN THIS ROOM KNOWS THE URGENCY OF FINDING WAYS TO MAKE AFFORDABLE, QUALITY LONG TERM CARE COVERAGE AVAILABLE TO THE MANY AMERICANS WHO NEED IT. MEDICARE PAYS ONLY 2% OF NURSING HOME EXPENSES AND PRIVATE INSURANCE COVERS ONLY 1%. THAT MEANS THAT MEDICAID AND

UNINSURED INDIVIDUALS NOW MUST STRUGGLE TO COVER THE MAJORITY OF THE FINANCIAL BURDEN THAT LONG TERM CARE MAKES NECESSARY.

EVERY TIME I GO HOME TO CALIFORNIA, I HEAR THE STORIES OF ANXIETY AND FEAR. WORKING INDIVIDUALS WORRY THAT WITHOUT AFFORDABLE LONG TERM CARE INSURANCE THEY MUST SAVE ENOUGH MONEY TO TRY TO PROTECT THEMSELVES AGAINST THE EVENTUAL ENORMOUS COSTS OF LONG TERM CARE. RETIRED ELDERLY WHO STILL LIVE INDEPENDENT LIVES AGONIZE THAT THEY WILL LOSE EVERYTHING THEY HAVE WORKED FOR BECAUSE THEY CANNOT AFFORD THE HIGH RATES OF PRIVATE INSURANCE. AND MANY ELDERLY NOW IN NURSING HOMES, LIVE IN ANXIETY AND FEAR AS THEY SPEND DOWN THEIR SAVINGS AND RISK BECOMING IMPOVERISHED.

WHILE CONGRESS LABORS OVER HOW TO HELP THOSE INDIVIDUALS SUFFERING RIGHT NOW BECAUSE THEY DID NOT HAVE THE OPPORTUNITY TO PLAN AHEAD FOR THEIR LONG TERM CARE NEEDS, WE CAN DO A GREAT DEAL TO MAKE SURE THAT TODAY'S WORKERS AND PERHAPS EVEN TODAY'S INDEPENDENT RETIREES DO NOT FIND THEMSELVES IN THE SAME AWFUL SITUATION AS THEY GROW OLDER. I HAVE SEEN MANY INTERESTING PROPOSALS WHICH WOULD ENCOURAGE PRIVATE INSURANCE COMPANIES AND EMPLOYERS TO OFFER QUALITY LONG TERM CARE COVERAGE. THE FINEST IDEA I HAVE SEEN THUS FAR CAME FROM THE OFFICE OF PERSONNEL MANAGEMENT. SENATORS DOLE, DURENBERGER AND I HAVE SINCE DRAFTED AND INTRODUCED LEGISLATION, S.1738, BASED ON OPM'S PROPOSAL. I HOPE TO ADD OTHER DISTINGUISHED MEMBERS OF THIS COMMITTEE AS COSPONSORS OF S.1738.

OPM PROPOSES TO OFFER OPTIONAL NURSING HOME AND HOME HEALTH CARE COVERAGE TO FEDERAL EMPLOYEES WHO WANT IT. SIMPLY STATED, WHEN A YOUNG BREADWINNER SELECTS AMONG EMPLOYER-OFFERED BENEFIT OPTIONS, HE OR SHE MOST LIKELY WILL BUY LIFE INSURANCE, DETERMINED TO PROVIDE SECURITY TO A YOUNG FAMILY. BUT, ONCE THE CHILDREN HAVE GROWN UP AND

BECOME INDEPENDENT, THAT FEDERAL EMPLOYEE BEGINS TO WORRY ABOUT HIS OR HER OWN INDEPENDENCE IN OLD AGE, AND ABOUT BECOMING A BURDEN TO THOSE CHILDREN.

OPM'S PLAN ALLOWS ALL FEDERAL EMPLOYEES REGARDLESS OF THEIR HEALTH STATUS, WHO HAVE REACHED THE AGE OF 50 AND PARTICIPATED IN THE LIFE INSURANCE PROGRAM FOR 10 YEARS, TO CONVERT THEIR LIFE INSURANCE TO LONG TERM CARE INSURANCE AT NO ADDITIONAL EXPENSE TO THE FEDERAL GOVERNMENT. SINCE LONG TERM CARE INSURANCE COSTS MORE THAN LIFE INSURANCE, THE EMPLOYEE WOULD HAVE TO PAY A SMALL ADDITIONAL PREMIUM (ABOUT $11.00 PER PAY PERIOD). BUT, THE FEDERAL GOVERNMENT WOULD REDIRECT THE CONTRIBUTION IT NORMALLY MAKES TOWARD THE EMPLOYEE'S LIFE INSURANCE, TO INSURANCE FOR LONG-TERM CARE. THESE TWO SOURCES PLUS THE RESERVES IN THE EMPLOYEES LIFE INSURANCE FUND WOULD PAY FOR THE NEW BENEFIT AND KEEP PREMIUM COSTS DOWN. OPM WOULD ALSO MAKE COVERAGE AVAILABLE TO SPOUSES, ALTHOUGH THE EMPLOYEE WOULD HAVE TO PAY THE FULL COST OF THE PREMIUM.

A POOL OF 3.1 MILLION ACTIVE FEDERAL WORKERS OFFERS A TEMPTING INCENTIVE FOR INSURANCE CARRIERS TO DEVELOP A COMPETITIVE LONG TERM CARE INSURANCE PROGRAM. TO DATE, ONLY ABOUT 423,000 LONG-TERM CARE INSURANCE POLICIES HAVE BEEN SOLD. 90% OF FEDERAL EMPLOYEES PARTICIPATE IN OPM'S LIFE INSURANCE PROGRAM AND 655,000 IMMEDIATELY WOULD BE ELIGIBLE WHEN S. 1738 BECOMES LAW. THIS PROPOSAL ALONE COULD DOUBLE THE NUMBER OF PEOPLE IN THIS COUNTRY WHO CURRENTLY HOLD LONG TERM CARE COVERAGE.

JUST AS IMPORTANTLY, BY TAKING THE LEAD TO CREATE A MARKET IN THIS AREA, THE FEDERAL GOVERNMENT CAN CREATE A LONG-TERM CARE "DOMINO EFFECT." WITH MORE INSURANCE CARRIERS ENTERING THE MARKET, EXISTING PROGRAMS WILL EXPAND TO OFFER COMPETITIVE SERVICES AND AS A RESULT OF THAT, PRICES WILL FALL. THE FALL IN PRICES PRESUMABLY

WILL MAKE IT POSSIBLE FOR PRIVATE COMPANIES AND STATE AND LOCAL GOVERNMENTS TO OFFER A LONG TERM CARE INSURANCE BENEFIT PLAN AND FOR INDIVIDUALS TO PURCHASE THEIR OWN PRIVATE COVERAGE.

CURRENTLY, PRIVATE LONG TERM CARE INSURANCE DOES NOT PLAY A BIGGER ROLE BECAUSE MOST INDIVIDUALS AND EMPLOYERS CANNOT AFFORD THE HIGH COST OF THE PREMIUMS. AS TWO OF TODAY'S PANELISTS, ALICE RIVLIN AND JOSHUA WEINER, POINT OUT IN THEIR EXCELLENT NEW BOOK, CARING FOR THE DISABLED ELDERLY:

> "GROUP INSURANCE ESPECIALLY GEARED TO THE NONELDERLY POPULATION WOULD POTENTIALLY ADDRESS THE PROBLEMS OF HIGH COST AND ADVERSE SELECTION. PREMIUMS SHOULD BE LOWER IN EMPLOYER-BASED GROUP POLICIES BECAUSE... PEOPLE WOULD BE ABLE TO CONTRIBUTE OVER THEIR ENTIRE WORKING CAREERS, ALLOWING RESERVES TO BUILD."

PLANS SUCH AS OPM'S, WILL MAKE LONG TERM CARE INSURANCE AVAILABLE TO THE MIDDLE CLASS AND TAKE IT OUT OF THE REALM OF A BENEFIT ONLY AVAILABLE TO THE WEALTHY.

CURRENTLY, CONGRESS DOES NOT HAVE A CONCRETE UNDERSTANDING OF HOW FAR THE PRIVATE SECTOR CAN GO TO MEET FUTURE LONG TERM CARE NEEDS. IT'S DIFFICULT TO DECIDE WHAT ROLE THE FEDERAL GOVERNMENT MUST PLAY IN FILLING IN THE GAPS BEFORE THE PRIVATE SECTOR HAS DEVELOPED ITS POTENTIAL.

MR. CHAIRMAN, IN YOUR BILL, YOU CREATE A PUBLIC/PRIVATE PARTNERSHIP IN MEETING THE NATION'S NEED FOR LONG TERM HEALTH CARE INSURANCE. THE VOTE ON THE PEPPER BILL SIGNALED THAT CONGRESS HESITATES THIS YEAR TO MOVE AHEAD IN DEFINING THE PUBLIC SIDE OF THAT PARTNERSHIP. BUT, I BELIEVE MEMBERS ARE READY TO

FACILITATE DEVELOPMENT OF THE PRIVATE PARTNER. S.1738 DOES JUST THAT. THE DATA THAT WILL RESULT FROM INCREASED PRIVATE SECTOR ACTIVITY IN THIS AREA WILL BE INVALUABLE AS CONGRESS CONSIDERS MORE COMPREHENSIVE PROPOSALS IN THE FUTURE.

THANK YOU AGAIN MR. CHAIRMAN FOR THE OPPORTUNITY TO SPEAK ON A SUBJECT OF SUCH CRITICAL IMPORTANCE. I LOOK FORWARD TO WORKING WITH YOU TO DEVELOP A NATIONAL POLICY ON LONG TERM CARE.

PETE WILSON
CALIFORNIA

COMMITTEES
ARMED SERVICES
AGRICULTURE, NUTRITION, AND FORESTRY
COMMERCE, SCIENCE, AND TRANSPORTATION
SPECIAL COMMITTEE ON AGING
JOINT ECONOMIC COMMITTEE

United States Senate
WASHINGTON, DC 20510

October 6, 1987

Dear Colleague:

It is now estimated that Americans who reach age 65 have a 43 percent risk of spending sometime in a nursing home during the rest of their lives. Yet, currently less than one percent of the elderly have long-term care insurance. Unfortunately, even the limited availability of long-term care insurance is so expensive that it is beyond the reach of most families. As a result, many individuals are unable to receive the care they need or in many cases are forced to sell virtually everything they own just to pay the bills, which average about $60 a day or $22,000 a year.

For this reason, I have introduced legislation to make long-term care (nursing home and home health care) insurance available to some 2.7 million federal workers in the hope that this action will stimulate employers in the private sector to offer their employees group coverage. Furthermore, the extension of long-term care insurance to federal workers will provide the insurance industry with valuable information that should encourage the growth of long-term care insurance nationwide.

Here's how the proposed option would work:

* When an employee reaches a minimum age of 50 with 10 years' participation in the Federal Employees Government Life Insurance Program (FEGLI) he would be given an opportunity to convert to long-term care insurance;

* He would convert a portion of the face value of his Basic FEGLI (e.g., $25,000) and associated reserve funds to long-term care insurance and would retain a minimum $2,000 death benefit;

* He would continue to pay his share of the regular Basic FEGLI premium for any amount of life insurance remaining and would pay an additional long-term care premium based on his age at conversion;

* He would receive stated dollar benefits for nursing home or alternative home health care in accordance with the specific long-term plan selected at the time of conversion;

* He would be eligible to purchase coverage for his spouse at group rates without evidence of insurability, and to purchase additional life insurance;

* The Government would continue to pay its usual contributions for Basic FEGLI but contributions associated with converted life insurance would be redirected to the long-term care option. (There is no additional cost to the Government.)

* Premium rates and dollar benefits would rise automatically with increases in the General Schedule pay scale.

In addition, employees ineligible for the FEGLI conversion, or who for any reason do not wish to convert, could elect the long-term care option. Because not everyone would be interested in long-term care insurance, participation in the program would be entirely voluntary.

Should you have any further questions, contact Bruce Millis at 224-5422.

I hope you will join me in this effort.

Sincerely,

Pete

PETE WILSON

COMMUNICATIONS

STATEMENT OF

THE AMERICAN ACADEMY OF NEUROLOGY

Mr. Chairman, the American Academy of Neurology appreciates the opportunity to submit a statement for the record on the Chairman's bill, S.2305, the Long Term Care Assistance Act of 1988. We welcome the efforts you, and your colleagues on this committee who have cosponsored this legislation, have expended in providing this forum to begin a much needed national debate on how this country-both the government and private sector -- should be involved in providing for the long term health care needs of this nation's citizens.

The American Academy of Neurology represents approximately 10,000 physicians specializing in the care of patients with neurological conditions or diseases. Among these are spinal cord and head injury cases, neurological impairment due to stroke, neuromuscular conditions such as cerebral palsy, muscular dystrophy and multiple sclerosis, and those suffering from Alzheimer's disease -- all of which necessitate a great deal of chronic, expensive care, frequently over the life-span of the individual, both in the home and in institutional settings.

Mr. Chairman, as neurologists, we know from from first hand experience in our practices the types of long term care needs our patients are confronted with, and those which they have difficulty getting access to, whether due to availability problems, or financial constraints. We see on a daily basis the costs these individuals and their families must bear, both in financial terms, and in terms of meeting the physical needs of the individual's condition. These conditions necessitate large financial expenditures to meet the health care needs, but also custodial and social care. The population we care for that has these needs is not restricted to those over age 65. The diseases we treat, and their debilitating effects are frequently not diseases of the aging process. Many of those needing long term care services are children, young adults, and individuals in the midst of their most productive working years.

Given our deep concern over the needs of the patients we treat, the American Academy of Neurology has carefully examined the issue of long term care insurance and developed positions on what we believe long term care insurance should cover (what services are needed that must be made accessible), who should be eligible and how it should be paid for and accomplished.

We welcome the Committee's perspective that the debate on long term care insurance has just begun, and that S.2305, as currently drafted, is a core of concepts from which we can begin to build a rational, valuable system to help meet our nation's long term care needs. With that idea in mind, we will address the major provisions of the Mitchell bill, pointing out those areas where we are in agreement with the proposals as drafted, and those where we find the need for a continued debate, and fine-tuning of the bill's language.

The Academy is particularly pleased to see the inclusion of custodial care and respite care in the coverage this bill would provide. It is the Academy's position that coverage for long term health care services should include various modalities of care such as hospital care, nursing home care, home care, respite care and day care. It is the Academy's position that whenever possible, care should be made available in the home situation. Incentives should be developed to conduct as much of the care -- both skilled and unskilled -- in the home environment whenever possible, or failing that, in a nursing home environment, such as a liscensed group home or nursing home. It is important to have these options available to the neurologist (and other physicians dealing with the long term care needs of their patients) to be able to put together a treatment and care plan that is best tailored to the individual's health and social needs.

The Academy believes that there are some specific services that are necessary in the treatment programs of many patients with neurological conditions and should be included as covered services in any long term care insurance program to be made available to persons with chronic, long term neurological illness. These include:

- Home health care should include such services as speech therapy, physical therapy, and occupational therapy for those indivuals who have achievable goals (as determined by their physician), and there should be mechanisms available to be able to fund their transportation needs to obtain these therapies while the patient resides in the home situation.

- Durable medical equipment, such as lifts, motorized wheelchairs, walkers, etc. which is extremely important for the success of home health care programs.

The Academy believes that both the public and private sectors should have major roles in financing long term care. This approach fosters personal responsibility for dealing with the problems of illness and aging, but also improves the chances that those who are in need of care will be able to obtain it. We agree with the concept that neither the public nor the private sector can be expected to carry the full burden of paying for long term care, and applaud the incorporation of this concept into legislation. We believe that any program established should present a variety of options to pay for long term care. These may include the elimination of the $45,000-a-year cap on annual wages subject to the Medicare payroll tax, an increase in the basic Medicare premium, a supplemental income-based premium, and a federal surtax on gifts or inheritance of some assets, as provided for in S. 2305. In addition, other options, such as tax credits, tax deferred interest on insurance premiums, medical IRAs, among others, may also be considered. We should also be looking at ways that government can provide such options, including the ability of the states, and not solely the federal government to do so.

A key element of S.2305 requires a two-year exclusionary period before Medicare begins to pay for nursing home benefits. The Academy believes that the concept of reducing the time for which an individual would need private insurance to two years to help make it affordable is a good one. However, given that the majority of nursing home stays (72 %) are under two years, we believe that the two year exclusionary period should be reduced.

The Academy is very concerned about the availability of long term care insurance to individuals of all ages. As stated above, as neurologists who treat chronically ill persons of all ages, we see the need for long term care insurance to be available, not just for the Medicare population (those over 65), or those below the poverty level (as the Medicaid buy-in would allow) but also for those individuals and families who face the costs of chronic care without any insurance coverage to meet those costs.

We recognize that this legislation, as currently drafted does allow for a Medicaid buy-in for those who are medically disabled and poor, or near-poor. However, we are concerned about another population of individuals who must bear the expense of chronic illness, without insurance coverage. It is frequently the case, where a family, with health insurance through the employer is still unable to support the costs of a long term, debilitating chronic illness because the health insurance does not cover the costs of such illnesses, or the costs reach the limits of what the policy will pay. Although the family is not destitute (at least not yet), there is no avenue for a family in that situation to afford such costs. In addition, there is no provision for the added costs of providing for child care, due to the inability of the ill spouse to function independently. The burdens of such a situation are also not strictly limited to financial ones, but fall upon family and friends.

S. 2305 as currently drafted does not address situations such as that described above, nor that of families where a child is the one who is suffering from disabling, chronic illness. The Academy believes that long term care financing should insure against the risk of financial destitution as a result of having to pay for the care of an individual once they cannot function independently, for the rest of their lives. Since this legislation makes a very good attempt at looking at ways that government and the private sector can both meet the long term care needs of the elderly, we ask that it be expanded to ensure that private sector insurance coverage is available, at an affordable rate, for those under 65, or not eligible for medicaid.

The success of a joint private and public sector approach to financing long term care will depend on the response of the private insurance industry and its ability to design and market affordable insurance policies.

The Academy believes that safeguards must be put in place to avoid the proliferation of policies touted as providing long term care benefits, but in actuality having so many loopholes and exclusions as to make them useless. In May of this year, *Consumer Reports* magazine published an indepth evaluation of existing private long term care policies. Of the 53 policies they looked at, *all* were said to have at least one major flaw. Some of the problems cited were:

- Persons with pre-existing health problems were often denied coverage. This is a critical problem for some of the people that neurologists treat with conditions such as Alzheimers disease, which are progressive. Serious functional impairment may not occur until after many years.

- The policies are expensive.

- Some only cover skilled and intermediate nursing care -- not custodial care that is commonly needed and very expensive.

- Almost three quarters of the policies required prior hospitalization before any benefit could be provided. This is in the face of statistics that show that sixty-one percent of patients enter nursing homes without being hospitalized.

- Very few policies had protection against inflation, thereby eroding the value of the policy over time. Since health care costs rise so quickly, outstripping general inflation, we would expect this to be a serious handicap.

Another conclusion drawn by *Consumer Reports* is that the variation in policy options is overwhelming to the average consumer, and denies the consumer the opportunity to effectively compare the merits of alternative policies. We have seen this type of problem before; it is not new. This Committee is well aware of the problems associated with the provision of medigap coverage -- and the unnecessary costs expended by the elderly in the mistaken belief that the policy purchased will provide the coverage needed. Safeguards must be established and consumers educated as to the limitations of coverage. The federal government and states should play an important role in regulating the insurance industry to assure appropriate standards of coverage, the establishment of guidelines for proper disclosure, protections against sales abuses, regulation of requirements of renewal and cancellation, requirements for sufficient reserves, and the development of benefit/premium ratios.

One of the most critical voids that needs filling is the creation of consumer demand for private insurance policies. To create a truly useful and workable program to meet the long term care needs of this nation, there needs to be a market of purchasers of the private insurance policies that we desire to proliferate. This is an especially acute problem for many of the neurological conditions that necessitate long term care, but are not part of the aging process, and necessitate many, many years of care, both in the home, and in institutional settings. For those under 65 years of age, incentives must be in place to ensure access to long term care insurance.

The Academy believes that any legislation that comes out of this Committee should provide for consumer education programs. Consumer education programs should emphasize the need for pre-funding anticipated costs of long term care needs. Consumer participation in private financing of long term care should be encouraged through a variety of modifications to the tax law. Mechanisms should be developed to encourage individuals to purchase long term care insurance, as well as for employers to offer such policies as part of employee benefit packages. The Academy would support changes to S. 2305 to accomplish this goal.

In conclusion, the American Academy of Neurology believes that the sponsors of this bill have made a very good start on the road to development of a valuable national program to provide for the long term needs of the elderly and poor. We support the bill's emphasis on a mix of public and private sector approaches to the financing of such care and the inclusion of custodial and respite care as long term care needs. We encourage this Committee to revise the bill to include persons of all ages with chronic illness, and to put into place provisions for consumer information programs, and quality safeguards to regulate the desired proliferation of private long term care insurance policies.

M-HW-0034d

STATEMENT
# of the
AMERICAN ASSOCIATION OF RETIRED PERSONS

The American Association of Retired Persons (AARP) commends the Chairman for his strong leadership on the issue of long-term care. AARP is pleased that the Chairman's legislation would begin to move the nation's long-term care system from a welfare to an insurance-based system. We appreciate the opportunity to comment on S.2305, The Long-Term Care Assistance Act of 1988 and the role of private long-term care insurance. The Association's statement for the record will focus on: (1) the need for long-term care coverage; (2) the potential of private insurance to solve the problem; (3) the need for consumer protection; (4) provisions to promote the development of private insurance; and (5) the need for a strong public role in long-term care financing.

The Need for Long-Term Care Coverage

Today, society in one way or another pays for the costs of long-term care. But it does so by placing inordinate burdens on a few individuals and their families, often robbing the family of dignity and independence in the process.

Older people and their families are bearing the brunt of practically all of the cost of community-based, long-term care. The vast majority of long-term care (71%) is provided in the community rather than in institutions. According to the 1982 National Long-Term Care Survey, nearly 3 out of 4 functionally impaired older Americans rely exclusively on unpaid sources of care provided by families and friends, and another 21% on a combination of support from families and paid providers. The unpaid caregivers are usually the wives and daughters of people needing long-term care. Caregivers often suffer economic and emotional hardships as a result of their role.

When older people with chronic illnesses must rely on formal long-term care services the expenses can be devastating. Nursing home stays account for over 80% of the expenses incurred by older people who experience very high out-of-pocket costs for health care (over $2,000 per year).

The need for long-term care leads almost inevitably to an unmanageable financial burden because the cost of care -- be it in an institution or in the home -- is often enormous. Medicare and private insurance combined pay only a minuscule proportion of nursing home costs (less than 3% in 1988). More than half of nursing home costs are paid out of the pockets of residents and their families. Most of the remaining costs, which average $25,000 per year, are paid by Medicaid because few people can afford the expense of an extended nursing home stay.

The cost and nature of long-term care demonstrate the need for an insurance approach based on shared risk: (1) relatively few persons in our society need long-term care at any one time; (2) it is difficult to predict who these individuals will be; and (3) the lifetime risk of needing nursing home care is much higher than most people think, e.g. estimates of the lifetime risk of institutionalization at age 65 range from 36% to 63%. These facts argue inherently for universal protection based on an insurance approach to the problem, where the costs to any one person can be small, while offering protection to all against financial devastation.

The Potential of Private Insurance to Solve the Problem

The private long-term care insurance market is relatively new, and, although this market will provide a great diversity of products to a larger number of people, we should not harbor unrealistic expectations about its potential. Many uncertainties and problems remain which cast doubts on the ability of the private market to provide adequate protection against the risk of needing long-term care coverage.

Sufficient data to accurately predict future use and costs of long-term care services are not yet available, especially for home care services. Current data on nursing home and home care utilization is fragmented and incomplete. Further, insurers must be concerned with a number of important variables such as inflation, regulatory control of provider supply and price, and the effects of new payment sources on the long-term care system.

The nature of this risk and how to manage it also are not well understood. Less is known about chronic disability than about acute care, and insurers have not yet been able to precisely define what is being insured - what types and levels of disability should trigger coverage. In addition, the problems of assessing health status (knowing when benefits begin) and controlling service use must be addressed. Insurers, like others, appear to believe that case management is the answer. While case management is useful for managing the delivery of long-term care, its effectiveness as a cost control tool is still an open question.

These uncertainties and problems cause insurers to place significant limitations on the risks they are taking and the coverage they offer. Thus, the policies on the market today have restrictions and exclusions that limit their effectiveness. Plans are generally not indexed for inflation and hence will fail to keep up with the escalating costs of care. For example, the Brookings Institution's report, "Caring for the Disable Elderly" found that if nursing home fees increase 5.8 percent per year, a $50 per day indemnity benefit would have to grow to more than $271 per day to maintain its purchasing power after thirty years.

Many plans require a substantial deductible. The many policies which still require prior hospitalization before covering a nursing home stay can effectively deny coverage to Alzheimer's patients and others whose need for long-term care services may not begin with an acute care episode. Non-skilled home care is infrequently covered, or a nursing home stay may be required in order to trigger home health benefits. Often, buyers are unaware of or do not understand the implications of these restrictions until their claims are denied.

Perhaps most important, current long-term care insurance policies are inaccessible to many older persons due to cost and underwriting restrictions. For most policies, the premium is determined by the age of the insured when he or she first buys the coverage. The monthly premium for a sixty-six year old is generally over $50; and for a seventy-six year old over $100. Few insurers will even sell to those over eighty years of age, and the premiums are prohibitive when coverage is available.

The Brookings Institution report indicates that a substantial proportion of the elderly might not be able to afford private insurance coverage and that the private sector cannot become the dominant form of long-term care financing.
Using the most optimistic assumptions about supply and demand, the research found that by the years 2016-20, only 25-40 percent of the elderly may be able to afford private long-term care insurance, and this insurance may account for a mere 7-12 percent of total nursing home expenditures. Additionally, this same amount of private coverage would have only a minimal effect on reducing Medicaid expenditures and the number of individuals who are impoverished by Medicaid eligibility requirements.

Additionally, even many people who could afford private insurance might not be able to purchase it because those with pre-existing conditions, such as Alzheimer's disease, are not eligible for most insurance plans. While this may be necessary to maintain stable premiums, it leaves persons with disabilities without any method to protect themselves from devastating long-term care expenses.

Private long-term care insurance also faces major demand problems for a variety of reasons. Most people seriously underestimate the risk of needing long-term care. Further, even those individuals who are aware of their statistical risk may deny that they themselves would ever be confronted with a disabling illness. Finally, many younger as well as older persons feel they cannot afford the premiums due to competing demands on their resources.

While the market for long-term care insurance is limited, there is potential for development of employer-based, long-term care insurance. These policies may be able to increase affordability and availability. For example, the newer generation of policies generally has fewer restrictions and provides more flexible benefit options. Protection against future long-term care expenses can be offered at lower cost by enrolling workers at a relatively young age. Aetna Life & Casualty recently reported that the average age of workers enrolling in a plan offered to its own employees was 42, and the average age in a plan sold to Proctor and Gamble was 40. Seven percent and 14% of the eligible workers, respectively, enrolled in the plans. While the young age of enrollees is a hopeful sign, the relatively low percentage of insured raises the question of how many younger workers will take advantage of such options.

In addition, many employers are justifiably concerned about creating new retiree health benefit liabilities when their ability to meet current obligations is in question. Recent changes in accounting standards may force employers to show these liabilities on their balance sheets. Estimates are that companies may have to show an unfunded liability for current retirees' health benefits of up to $85 billion.

Clearly, there are obstacles to be overcome before employer-based coverage could become a meaningful part of the solution to the need for long-term care coverage. And, even if these obstacles can be overcome and a significant percentage of people buy long-term care insurance, there will be those who are uninsured or unable to afford coverage who will be left out of the private insurance system and dependent on Medicaid for protection.

Another limitation of private insurance is that insurers have expenses that a public insurance program does not. Insurers must advertise and market their policies. In addition, insurers must make a profit or add to their surpluses. In comparison, the Medicare program returns significantly more in benefits and services for every dollar taken in than most insurers. Ninety-eight percent of all disbursements under the hospital insurance (HI) program went for benefit payments last year with only 1.6 percent spent on administrative expenses, according to the 1988 Annual Report of the Board of Trustees. In most cases, insurers must return 60 cents in benefits for every dollar of earned premiums.

The Need for Consumer Protection

Consumers must be protected from inadequate long-term care insurance policies and misleading marketing practices. The growth of the market suggests the need for increased state and federal regulation of long-term care products. An important first step toward regulation was taken this past year by the National Association of Insurance Commissioners (NAIC), which developed a Model Long-Term Care Insurance Act that has been adopted by at least 12 states. The Model Act sets state standards for regulation of long-term care insurance and requires that policies cover at least one year of non-acute services. This past December, the NAIC adopted a Model Regulation designed to implement the Act. The models continue to improve as the insurance commissioners consider new methods of protecting consumers.

As a result of the evolving nature of long-term care products, the NAIC chose to focus the Act and the Regulation on disclosure and product performance (e.g., renewability) standards rather than on regulation of benefits. Given how little is known about the demand for long-term care insurance and the best way to structure protection, the decision not to regulate benefits is understandable. Yet many insurers and agents are taking advantage of the benefit restrictions and limitations in some policies to mislead older persons and to sell them policies that do not meet their needs. Many states have increased their efforts to deal with misleading and abusive practices, but their successes remain limited.

Because of the potential for abuse, AARP believes that federal oversight of the long-term care insurance industry is necessary. Federal standards could play a valuable role in consumer protection by (1) assuring that long-term care insurance is marketed and sold in a fair and informative manner; and (2) eliminating certain limitations and restrictions that cause confusion and reduce the value of policies. Some of the standards which AARP believes would be useful follow:

(1) A long-term care policy which provides coverage for nursing home confinement should, at minimum: (1) provide coverage in skilled nursing and intermediate care facilities and (2) provide coverage for all levels of care (skilled nursing care,

intermediate care and custodial care) lawfully provided in any state-licensed nursing home.

(2) A long-term care policy should not condition benefits for confinement in a nursing home on a prior confinement in another facility. A long-term care policy which provides benefits for nursing home confinement should not condition benefits for intermediate care or for custodial care on either the prior receipt of skilled nursing care or intermediate care or a prior confinement in a skilled nursing home or an intermediate nursing facility.

(3) A long-term care policy which provides benefits for home health care should not provide benefits only for skilled nursing care and should not condition benefit eligibility on the need for skilled nursing care.

(4) A long-term care policy which provides benefits for home health care should not condition them on the prior receipt of Medicare reimbursed home health care services or use eligibility requirements or standards that are the same or substantially similar to the rules and guidelines defining eligibility for Medicare home health benefits.

(5) A long-term care policy which provides for home health care should not condition benefits on the prior receipt of hospital or nursing home care.

Finally, consumer education about long-term care insurance is essential. States should provide consumers with brochures that compare the benefits of insurance policies sold in the state and insurers should provide clear outlines of coverage to applicants.

Provisons to Promote the Development of Private Insurance

S.2305 has three major provisions that could increase the availability of private insurance: (1) permitting interest on long-term care insurance reserves to accumulate tax-free; (2) making long-term care insurance a non-taxable benefit for employers; and (3) a two-year exclusionary period for nursing home coverage.

Permitting the interest on reserves for long-term care policies to accumulate tax-free could reduce premium costs because insurers' tax burdens would decrease. This treatment is accorded to life insurance. Many argue that long-term care insurance should receive the same tax treatment as life insurance because, like life insurance, an integral part of long-term care insurance products is the accumulation of funds over time to pay for benefits.

This approach seems desirable, especially if long-term care insurance products can be developed that are attractive to younger workers and their employers. Given appropriate provisions to curb abuse, the long tax-free accumulation of interest could substantially reduce premium costs. The Treasury Department is examining tax treatment for long-term care insurance and its findings should be carefully considered.

S.2305 also would give long-term care insurance the same tax treatment that health insurance now enjoys. Thus, long-term care insurance would become a non-taxable benefit for employees and could become more financially attractive. This approach raises several issues.

(1) There could be substantial tax losses. To deal with this issue the following questions must be answered. What is the potential tax loss? Will the tax loss be offset by cost savings to programs such as Medicaid? Is a tax loss the most efficient method of financing long-term care?

(2) People with high incomes generally benefit the most from tax deductions. Should society subsidize the purchase of long-term care insurance for those who can most easily afford it?

(3) Will providing tax advantages for long-term care insurance lead to an additional benefit for employees or will employers reduce essential acute care coverage when they increase coverage for long-term care insurance?

A third provision that could lead to a higher demand for long-term care insurance is S.2305's two year exclusionary period that would delay nursing home coverage until a person had paid for the first two years of care. AARP is concerned about this provision.

Ideally, all of these individuals - and others requiring longer nursing home stays - would have sufficient personal resources or adequate insurance to pay for nursing home costs during the exclusionary period. But this scenario is highly unlikely for a number of reasons.

(1) Affordability. A significant number of elderly people will not have the income necessary to either pay for their own care or to purchase long-term care insurance. For example, the populations most likely to need nursing home care - women and the very old - are also more likely to be poor.

(2) Limited Accessibility. Many individuals will not be able to buy long-term care policies because of underwriting restrictions that exclude people who are likely to use services (e.g., disabled populations).

(3) Inadequacy of long-term care insurance policies. Since insurers are afraid of potentially large financial losses, long-

term care policies generally have serious limitations, such as prior-institutionalization requirements.

(4) Limited Demand. Most people seriously underestimate their own risk of needing long-term care. Given this, they may not see the need to purchase long-term care insurance to cover a two year deductible.

The Need for a Strong Public Role in Long-Term Care Financing

The government must play a much stronger role in directly financing long-term care. Neither private sector initiatives alone nor tax-subsidized efforts can solve this problem. Thus, while private sector activity that may develop new and innovative mechanisms for delivering and reimbursing such care should be encouraged, there is a need for a comprehensive public long-term care program based on the principles of social insurance and shared risk.

Our nation has had a long and successful tradition of providing protection through social insurance against risks that threaten the basic security of Americans. Social Security, for example, has proven effective in providing basic protection against the risk of lost earnings due to retirement, disability, and death. Medicare has made major strides in protecting acutely ill older people from unmanageable health care expenses.

AARP believes that universal protection against the financial burdens of long-term care is needed to provide a true "safety net" for all Americans. Thus there is a need for a public program that provides basic long-term care coverage. People could use their savings or private insurance to fill in any gaps in coverage. Such a program must be designed to work in tandem with private sector approaches so that private insurance products complement the public long-term care system.

STATEMENT OF

THE AMERICAN COLLEGE OF GASTROENTEROLOGY

Submitted by Edwin M. Cohn, MD, FACG

Mr. Chairman, the American College of Gastroenterology appreciates the opportunity to submit a statement for the record on the Chairman's bill, S.2305, the Long Term Care Assistance Act of 1988. We welcome the efforts you, and your colleagues on this committee who have cosponsored this legislation, have expended in providing this forum to begin a much needed national debate on how this country-both the government and private sector -- should be involved in providing for the long term health care needs of this nation's citizens.

The ACG represents approximately 2,600 physicians specializing in the care of patients with gastrointestinal diseases. Mr. Chairman [illegible] gastroenterologists, we know from first hand experience in our practices the types of long term care needs many of our patients with diseases such as portal cirrhosis, and its complications of ascites, portal hypertension associated with esophageal varices, hyperbilirubinemia, malnutrition; biliary cirrhosis; chronic inflammatory bowel disease complicated by fistula formation and malnutrition; and carcinoma of the gastrointestinal tract. We see consistently the costs these individuals and their families must bear, both financially and the physical sacrifices required to support a patient with a chronic illness. These conditions necessitate large financial expenditures to maintain the needs caused by impaired health as well as the custodial and social care. Much of these services are either unavailable to many of our patients, or inaccessible due to the high costs involved. The population requiring such overall care is not restricted to those over age 65. The diseases and their debilitating complications are not solely diseases of the aging process. Long term care service needs are problems found in children, young adults, and individuals in the midst of their most productive working years.

Given our deep concern over the needs of the patients we treat, the American College of Gastroenterology has carefully examined the issue of long term care insurance and developed positions on what we believe long term care insurance should cover in regard to the services that are needed, and how to provide accessibility. In addition, decisions are required to determine who should be eligible and how funding should be provided.

We welcome the Committee's perspective that the debate on long term care insurance has just begun, and that S.2305, as currently drafted, is a core of concepts from which we can begin to build a rational, valuable system to help meet our nation's long term care needs. With that idea in mind, we will address the major provisions of the Mitchell bill, pointing out those areas where we are in agreement with the proposals as drafted, and those where we find the need for a continued debate, and fine-tuning of the bill's language.

ACG is particularly pleased to see the inclusion of custodial care, and respite care in the coverage this bill would provide. It is the College's position that coverage for long term health care services should include various modalities of care such as hospital care, nursing home care, home care, respite care and day care. Each of these should be available for the physician to be able to put together a treatment and care plan that is best tailored to the individual's health and social needs. The qualifications of agencies and individuals that provide services to eligible patients ought to be examined and certified. States and/or local communities should regulate this process.

ACG believes that both the public and private sectors should have major roles in financing long term care. This approach fosters personal responsibility for dealing with the problems of illness and aging, but also improves the chances that those who are in need of care will be able to obtain it. We agree with the concept that neither the public nor the private sector alone can be expected to carry the full burden of paying for long term care, and applaud the incorporation of this concept into legislation. We believe that any program established should present a variety of options to pay for long term care. These may include the elimination of the $45,000-a-year cap on annual wages subject to the Medicare payroll tax, an increase in the basic Medicare premium, a supplemental income-based premium, and a federal surtax on gifts or inheritance of some assets, as provided for in S. 2305. In addition, other options, such as tax credits, tax deferred interest on insurance premiums, medical IRAs, among others, may also be considered. We should also be looking at ways that government can provide such options, including the ability of the states, and not solely the federal government to do so.

A key element of S.2305 specifies two-year exclusionary period before Medicare begins to pay for nursing home benefits. ACG believes that the concept of limiting the time is plausible (for which an individual would need private insurance to help make it affordable). However, given that the majority of nursing home stays (72 %) are under two years, we believe that the two year exclusionary period should be reduced.

The College is very concerned about the availability of long term care insurance to individuals of all ages. As stated above, as gastroenterologists who treat chronically ill persons of all ages, we see the need for long term care insurance to be available, not just for the Medicare population (those over 65), or those below the poverty level (as the Medicaid buy-in would allow) but also for those individuals and families who face the costs of chronic care without any insurance coverage to meet those costs.
We recognize that this legislation, as currently drafted does allow for a Medicaid buy-in for those who are medically disabled and poor, or near-poor. However, we are concerned about another population of individuals who must bear the expense of chronic illness, without adequate insurance coverage. Frequently, a family dependent alone on the health insurance provided through the employer will be unable to support the costs of a long term, debilitating chronic illness because the health insurance does not cover the costs of such extended illnesses, and the various supportive measures that are required. Although the family is not destitute early in the course of ilness there is no avenue for a family in that situation to meet such ongoing costs. In addition, there is no source for the added costs to provide for child care, when a parent is unable to provide that care. The burdens of such a situation, with limited resources, economically and physically, by necessity fall upon family and friends.

S. 2305 as currently drafted does not address situations such as that described above, nor that of families where a child is the one who is suffering from disabling, chronic illness. ACG believes that long term care financing should insure against the risk of financial destitution as a result of having to pay for the care of an individual once they cannot function independently. Since this legislation makes a very good attempt at looking at ways that government and the private sector can both meet the long term care needs of the elderly, we ask that it be expanded to ensure that private sector insurance coverage is available, at an affordable rate, for those under 65, or not eligible for medicaid.

The success of a joint private and public sector approach to financing long term care will depend on the response of the private insurance industry and its ability to design and market affordable insurance policies.

ACG believes that safeguards must be put in place to avoid the proliferation of policies touted as providing long term care benefits, but in actuality having so many loopholes and exclusions as to make them useless. In May of this year, Consumer Reports magazine published an indepth evaluation of existing private long term care policies. Of the 53 policies they looked at, all were said to have at least one major flaw. Some of the problems cited were:

- Persons with pre-existing health problems were often denied coverage. If pre-existing illness were present which did not interfere with the independence of the individual, or cause restricted activities early in the course of the disease, insurance policies should not consider the individual ineligible for long term care coverage when the advanced stages of such illness have become manifest. At this time the ravages of the disease may be responsible for rendering the patient incapable of self-care and supportive care would be required.

- The policies are expensive.

- Some only cover skilled and intermediate nursing care -- not custodial care that is commonly needed and very expensive.

- Almost three quarters of the policies required prior hospitalization before any benefit could be provided. This is in the face of statistics that show that sixty-one percent of patients enter nursing homes without being hospitalized. This is frequently the case with patients gastroenterologists treat with diseases such as chronic liver disease with malabsorption anemia and under-nutrition; granulomatous disease of the small bowel with stricture, malabsorption and fistula development.

- Very few policies had protection against inflation, thereby eroding the value of the policy over time.

Another conclusion drawn by Consumer Reports is that the variation in policy options is overwhelming to the average consumer, and denies the consumer the opportunity to effectively compare the merits of alternative policies. We have seen this type of problem before; it is not new. This Committee is well aware of the problems associated with the provision of medigap coverage -- and the unnecessary costs expended by the elderly in the mistaken belief that the policy purchased will provide the coverage needed. Safeguards must be established and consumers educated as to the limitations of coverage. The federal government and states should play an important role in regulating the insurance industry to assure appropriate standards of coverage, the establishment of guidelines for proper disclosure, protections against sales abuses, regulation of requirements of renewal and cancellation, requirements for sufficient reserves, and the development of benefit/premium ratios.

One of the most critical voids that needs filling is the creation of consumer demand for private insurance policies. To create a truly useful and workable program to meet the long term care needs of this nation, there needs to be a market of purchasers of the private insurance policies that we desire to proliferate. ACG believes that any legislation that comes out of this Committee should provide for consumer education programs. Consumer education programs should emphasize the necessity for pre-funding projected costs of long term care requirements. Consumer participation in private financing of long term care should be encouraged through a variety of modifications to the tax law. Mechanisms should be developed to encourage individuals to purchase long term care insurance, as well as for employers to offer such policies as part of employee benefit packages. ACG would support changes to S. 2305 to accomplish this goal.

In conclusion, the American College of Gastroenterology believes that the sponsors of this bill have made a very good start on the road to development of a valuable national program to provide for the long term needs of the elderly and poor. We support the bill's emphasis on a mix of public and private sector approaches to the financing of such care and the inclusion of custodial and respite care as long term care needs. We encourage this Committee to revise the bill to include persons of all ages with chronic illness, and to put into place provisions for consumer information programs, and quality safeguards to regulate the desired proliferation of private long term care insurance policies.

WRITTEN STATEMENT
OF THE
AMERICAN INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS

The American Institute of Certified Public Accountants (AICPA) welcomes the opportunity to provide written comments on the long-term status of the Social Security trust fund reserves. The AICPA has a membership of more than 260,000 CPAs. The Federal Taxation Executive Committee has the authority to develop and communicate positions on tax policy matters on behalf of AICPA.

The Executive Committee through its subcommittee on Tax Policy, has had a continuing interest in the Social Security system since 1976, when it organized a Social Security Task Force to address issues of concern involving the system. The Federal Taxation Executive Committee issued a Statement of Tax Policy (No. 8) in 1980 entitled Suggested Improvements for the Social Security Retirement System. This Statement was revised, expanded, and reissued in 1987. A copy of the Statement is enclosed with this testimony. As described more fully in the enclosure, the Statement advocates a change in the philosophy of the Social Security program, with emphasis placed on "individual equity" rather than "social adequacy." The AICPA maintains that the "social adequacy" (income transfer) elements of the present system should be part of the general revenues budget. Although the focus of the Statement is on the benefit structure of the program, these recommendations have financing implications as well.

The Social Security program touches the lives of almost all Americans. During 1987, approximately 128 million workers contributed to the system and 38.1 million persons collected retirement or disability benefits. Revenues from Social Security taxes comprise approximately 36.8 percent of total federal revenues, almost as much as the amount raised by individual income taxes. While the collective effect of tax legislation in the 1980s has reduced individual income taxes for the period 1987-91 by $1.105 trillion, Social Security taxes have increased by $133 billion during the same period of time.[1] It is noted in the Special Analysis, Budget of the United States Government, 1989 that "[a]s a result of the rapid rise in social insurance taxes (mainly Social Security) and the passage of legislation reducing or eliminating individual income taxes for many low- and moderate- income individuals and families, millions of Americans now pay significantly higher social insurance taxes than income taxes" [p. B-4].

The Social Security programs have operated since their inception on the concept of "pay-as-you-go" or "current cost" financing. Under such a philosophy, the funds currently received are used to finance current benefits. Trust funds serve as contingency reserves to guard against fluctuations due to unforeseen changes in economic conditions. The "pay-as-you-go" approach creates unique inter-generational compacts between current beneficiaries, current workers, and future generations of workers. In the absences of any funded retirement system, the tax rates borne by current workers is determined by the need for current funds and bears no direct relationship to the amount of future benefits that these workers will be entitled to receive. Traditionally, a fund ratio of 75 percent (9 months of benefit payments in reserve) has been considered appropriate.

The status of the Social Security trust funds has been the subject of legislative concern during most of this decade. During the early 1980s, it was the impending insolvency of the old-age and survivors (retirement) fund that received much publicity. Such insolvency was avoided by stop-gap measures such as interfund borrowing and longer range measures such as the Social Security Amendments of 1983. Among the major provisions of the 1983 Social Security Amendments were an increase in Social Security tax rates (reaching 7.65 percent for the employee and employer in 1990), an expansion of mandatory coverage, income taxation of a portion of retirement benefits, and an increase in the "normal" retirement age (from age 65 to 67 by the year 2027).

During the past two years, the trust funds have again received public attention, this time because of what might be described as an "embarrassment of riches." The 1988 Annual Report of the Board of Trustees of the retirement trust fund (old-age and survivors) projects the fund to reach a fund ratio of 587 percent (531 percent if the disability trust fund is included) by the year 2015 (under the "intermediate" (II-B) economic assumptions). Historically, the fund ratio has not exceeded 100 percent since the early 1970s. Total assets of the combined retirement and disability trust funds are projected to reach $11.8 trillion by the year 2030 (again using the II-B economic assumptions). This dramatic reversal in fortunes can be attributed to sustained economic growth (in the short run) and increases in tax rates and coverage (in the long run). The net result of this build-up has been to create a quasi-funded system rather than a true pay-as-you-go system, at least in the near term. The report also projects that the funds will be exhausted by the year 2048 under intermediate economic assumptions (and 2026 under "pessimistic" economic assumptions). In other words, while it will take 42 years to build the trust funds to their expected maximum amount, it will take only 16 years to exhaust that reserve.

The challenge facing the Social Security program currently has been succinctly summarized by the Government Accounting Office (GAO) in its report Social Security Funds, Additional Measures Could More Fully Indicate the System's Financial Condition (issued February, 1988). The GAO notes that the Social Security program faces a dual challenge, that "[a]t the same time that the size of the trust fund reserves is increasing, the long-term position of OASDI is becoming less favorable." Beginning in the year 2020, the effects of the change in demographics of this country will begin to be evident. The "baby boom" generation will begin retiring in significant numbers. They will be supplanted by a smaller (relative) workforce, the result of declining fertility rates. A retiree in the year 2030 will be supported by 2 workers, compared to 5.1 workers in 1960, and 3.8 workers in 1987. In addition, advances in medicine will extend the average length of retirement, thereby increasing the number of years of payments made to the average beneficiary. During the middle part of the 21st century, significant changes will have to be made in the Social Security program, either by way of higher taxes on current workers or lower benefits on current retirees. Judging from the current political influence of retired persons, it seems reasonable to suggest that the former, rather than the latter, course of action will likely occur.

The current debate over the impending surplus of Social Security trust funds in the near term centers around the economic effect such a surplus is likely to have on saving and capital markets. In addition, the "presentation" of this surplus within the budget also has received much debate. Some legislators have expressed concern that large surpluses will drain money from the economy and that the surplus could become so large that it could be used to retire the entire federal debt. The entire federal debt would then be owed to the Social Security trust fund, which would obviate the need for the Treasury to issue government securities to the public. Others have argued that the surplus should be allowed to accumulate, at least until it reaches a fund ratio of 100 percent (around 1991), in order to help restore public confidence in the system and to increase national savings. Many witnesses at recent hearings have expressed concern that keeping the surplus as part of the general budget obscures the "true" deficit picture and will tempt Congress into using such surpluses to subsidize other government expenditures.

Position of the AICPA

In our Statement of Tax Policy No. 8 (Suggested Improvements for the Social Security Retirement System) we endorsed continuance of the "pay-as-you-go" concept of benefit financing. We favor the existence of a trust fund that contains a reserve of between six and nine months of benefit payments. A "fully funded" program would build reserves of such an enormous magnitude that there might well be a deleterious effect on the private capital markets.

We have not, however, endorsed retention of the current benefit structure of the Social Security program. This is an important point, because our recommendation of a "pay-as-you-go" system is based on significant changes in the benefit structure of the program. The use of Social Security taxes to finance income transfer payments to lifetime low-wage earners results in the need for higher taxes and subjects the program to dramatic swings in fund ratios due to demographics and economic vagaries. When retirement benefits are not related to retirement "contributions," there may well be a temptation by the Congress to increase benefits without a corresponding fiscal discipline to increase taxes. The net effect of such policies is evident when one notes the decline in the ratio of "expected benefits" to "expected contributions" for current workers relative to current retirees (see Tables 2.1 - 2.4 of enclosed Statement No. 8). In fact, a married couple beginning work in 1985 and earning at the Social Security wage and contribution base will have to collect benefits for almost seventeen years to recoup the expected future value of their employee-paid tax payments at a 3 percent real rate of return (34 years are required to collect both the employee and employer-paid taxes).[2] The same married couple retiring in 1985 needs to collect benefits for only 5.5 years to recoup their employee-paid taxes under the same assumptions. A married couple beginning work in 1985 and each earning the "average" annual wage needs to collect benefits for 10.5 (21) years to "breakeven," while the corresponding couple who retired in 1985 needs to collect benefits for only 4.8 (9.6) years.

The program changes recommended in our Statement of Tax Policy would separate the "individual equity" aspects of the retirement program from the "social adequacy" aspects of the program. The "individual equity" element of the retirement system would be funded by Social Security taxes, whereas the "social adequacy" elements would be funded by general revenues. The other key points recommended in the Statement can be summarized as follows:

1. The present three-tiered benefits structure should be replaced by a level benefit structure in which benefits are directly related to each worker's contributions to the retirement system. An individual's total contributions would include the retirement portion of both the employee- and employer-paid contributions, increased by an earnings factor that includes a real rate of return. Income transfer payments, however determined, should be funded by federal general revenues.

2. Settlement options selected at the time of retirement should include (a) a joint-and-survivor annuity (for married couples), (b) a single-life annuity, or (c) an annuity with a guaranteed refund feature under which the total retirement contributions (increased by a real rate of return) would be guaranteed to either the retiree or the estate.

3. The retirement annuity should begin at what Congress determines to be an appropriate "normal retirement age."

4. For income tax purposes, the retirement portion of the Social Security tax assessed against employees and self-

employed persons should be deductible when it is paid, and retirement benefits should be fully taxable when they are received.

5. Coverage under Social Security should be mandatory for all workers, with exceptions for short-term nonresident alien workers.

6. In the event of death prior to retirement, the individual's accumulated Social Security contribution should be paid to the estate.

7. The concept of earnings sharing should be explored as one means by which the contributions records of each spouse would be determined.

We also recommend that the following additional goals be adopted in conjunction with the suggested changes to the Social Security program:

1. The Social Security program should be viewed as one part of a broader national retirement income program, the other two parts being private savings and employment-related pension programs. The role of Social Security should be to provide a basic floor of protection for every worker who has spent a substantial portion of his or her working life under the Social Security program, but not to provide the sole means of support.

2. Congress should continue to provide incentives to promote increased private savings and the expansion of the private pension system.

3. There should be a federally funded study to establish a valid minimum income level for retired persons and to examine the economic implications of these recommendations.

Adoption of changes such as those advocated above will take time to implement and transition rules will be required. During this time, the problems of growing Social Security surpluses and growing budget deficits will need to be addressed. We advocate the following positions during the interim period:

1. Consistent with the individual equity philosophy of Statement No. 8, the Social Security surplus (or deficit) should not be part of the general budget. The Congressional Budget Office and the Office of Management and Budget present the following deficit projections with and without Social Security (in billion of dollars):

	1988	1989	1990	1991	1992	1993
CBO Projections						
with social security	161	177	170	159	154	139
w/out social security	198	223	228	230	235	236
OMB Projections						
with social security	148	138	111	86	63	39
w/out social security	184	184	169	156	143	132

Source: Senate Budget Committee Report (100-311) on Fiscal 1989 Budget Resolution (SConRes 113), as approved by Committee March 30, 1988.

Using the Social Security surplus to mask additional deficit spending of general revenues allows Congress the opportunity to postpone the exercise of restraint on government spending or the imposition of higher taxes, either or both of which would be necessary to reduce the deficit. The Social Security trust funds are unique from other trust funds (highway, etc.) because they are earmarked for future liabilities rather than current consumption. Using Social Security surpluses to subsidize current consumption postpones hard decisions that need to be made now.

2. Congress should proceed with caution before it makes a decision on the appropriate level of Social Security trust fund reserves. Increasing benefits and/or decreasing taxes in the short run seems to us as very short sighted. In its report on the status of Social Security funds, the GAO projects that a tax rate reduction to 10.8 from 12.4 percent for 1990 and beyond would accelerate the exhaustion date of the trust funds (OASDI only) by 25 years. A benefit increase of 15 percent would have the same net effect. While these two options are politically appealing, it would seem to us that either of these actions would increase the future tax burden of working Americans at the expense of short term gratification. While the projected surplus under the present system is potentially enormous, it also should be noted that while it will take 42 years to build such a surplus, it will take only 16 years to deplete it. If no such surplus exists in the year 2015, the cost to the then current workforce to fund current retirees would be so high that it is likely that public support for the current system would wane.

3. Most of all, Congress needs a vision for the future when legislating change in the Social Security program. The 50 years since the Social Security program was initiated have seen significant economic and cultural changes, e.g., the

great increase in two income families; an extended life span; earlier retirement (often followed by a second career); a tremendous growth in employer provided retirement programs; and a significant decrease in the number of elderly people living with their children. It is not at all clear that the Social Security system has changed accordingly.

We agree with Dorcas Hardy, current Commissioner of the Social Security Administration, who wrote:

> My own vision of Social Security's future is seen through a mirror to its past. The founders of the program envisioned the system as a base upon which to build a complete package of protection. Unfortunately, the success of the program has led to an exaggeration of it capabilities. I believe Social Security should get back to basics and provide a "floor of protection" to be supplemented, not replaced, with pensions, savings, and other investments. In sum, each individual must take responsibility for ensuring his or her own financially secure retirement.[3]

The AICPA welcomes the opportunity to participate in the ongoing discussions about the Social Security program, and we appreciate the opportunity to contribute to the current debate.

REFERENCES

1. Office of Management and Budget, The United States Budget in Brief, 1989, p. 46.
2. Edmund Outslay, "An Analysis of the Effect of the 1983 Social Security Amendments on Individual and Family Equity," Contemporary Tax Research (University of Oklahoma Press, 1988) pp. 76-109.
3. Dorcas R. Hardy, "The Future of Social Security," Social Security Bulletin, August 1987, p. 7.

STATEMENT OF

THE AMERICAN RHEUMATISM ASSOCIATION
TO THE SENATE FINANCE COMMITTEE

The ARA appreciates the opportunity to submit a statement for the record on the Chairman's bill, S.2305, the Long Term Care Assistance Act of 1988. We welcome the efforts you, and your colleagues on this committee who have cosponsored this legislation, have expended in providing this forum to begin a much needed national debate on how this country-both the government and private sector -- should be involved in providing for the long term health care needs of this nation's citizens.

Mr. Chairman, the ARA is the largest professional organization of physicians and scientists devoted to the study and treatment of rheumatic disease. A rheumatologist is a physician specialist who provides medical care to the patients with diseases of the joints, muscles, and bones. Osteoarthritis, rheumatoid arthritis, gout, lupus, bursitis, back pain, and osteoporosis represent some of the more than 100 types of rheumatic syndromes. More than 37 million people in the United States have some form of rheumatic disease. These disorders are a leading cause of disability and absence from work in the United States. By special training and expertise, the rheumatologist is uniquely qualified among physician specialists to provide care for people with rheumatic diseases in a high quality and cost-effective manner, and to lead the team of health professionals who assist in treating these diseases.

As rheumatologists, we know from first hand experience in our practices the types of long term care needs people with arthritis or other rheumatic diseases have. We see on a daily basis loss of dexterity, mobility and eventually independent functioning that necessitates both increased support of family and friends, but also custodial, social, and professional health care. Many of these services are either unavailable to arthritis patients, or inaccessible due to the high costs involved. The diseases we treat, and their debilitating effects are not solely diseases of the aging process. A substantial number of persons with rheumatic diseases is under 65. It is not unusual for a rheumatology practice to be made up of no more than one-third Medicare patients. A substantial number of persons with rheumatic diseases is under 65. Many of those needing long term care services are children, young adults, and individuals in the midst of their most productive working years.

Given our deep concern over the needs of our patients, the American Rheumatism Association has carefully examined the issue of long term care insurance and developed positions on what we believe such insurance should cover. Our positions address the following issues: 1) what types of services are needed; 2) access and eligibility requirements; 3) payment mechanisms and insurance options.

We welcome the Committee's perspective that the debate on long term care insurance has just begun, and that S.2305, as currently drafted, is a core of concepts from which we can begin to build a rational, valuable system to help meet our nation's long term care needs. With that idea in mind, we will address the major provisions of the S.2305 pointing out those areas where we are in agreement with the proposals as drafted, and those where we find the need for a continued debate, and fine-tuning of the bill's language.

The Role of Rheumatologists in Long Term Care

Rheumatologists have long standing expertise with both the acute and non-acute care needs of people with rheumatic diseases. Due to the potential adverse effects of these diseases on musculoskeletal function, we have long been involved in leading a team of health professionals whose goal is to design and implement comprehensive rehabilitation programs. We work closely with, and advise allied health professionals such as occupational therapists, physical therapists, nurses, social workers and others, all of whom are committed to helping the person with arthritis lead the most functionally independent life possible. Through training and experience rheumatologists have the skills which enable them to effectively assess therapy (type, duration, and probable outcome),

This involvement in the non-acute care needs of people with arthritis has led rheumatologists to be acutely aware of their home care needs, both medical and custodial. Therefore the ARA is particularly pleased to see the inclusion of custodial care, and respite care in the coverage this bill would provide. It is the ARA's position that coverage for long term health care services should include hospital care, nursing home care, home care, respite care and day care.

Assuring the Availability of Long Term Care

As stated above, as rheumatologists who treat chronically ill persons of all ages, we see the need for long term care insurance to be available, to all, not just for the Medicare population or those below the poverty level (as the Medicaid buy-in would allow).

We recognize that this legislation, as currently drafted does allow for a Medicaid buy-in for those who are medically disabled and poor, or near-poor. However, we are concerned about another population of individuals who must bear the expense of chronic illness, without long term care insurance coverage. Frequently, families who are not destitute, or near poor (at least not yet) are faced with the high costs of caring for chronic, long term illness. They may be families with employer provided health insurance coverage, but such coverage does not commonly include meeting the costs of debilitating, chronic illness. The long term care needs are not limited to the expenses of caring for the individual, but often, when the individual with the disabling illness is the mother, with primary responsibility for child care, there is also need for help in paying for the added costs of providing for child care, due to the inability of the ill spouse to function independently. (Females are more frequently affected by many rheumatic syndromes). The burdens of such a situation are also not strictly financial, but fall upon family and friends.

S. 2305 as currently drafted does not address situations such as that described above, nor that of families where a child is the one who is suffering from disabling, chronic illness. The ARA believes that long term care financing should insure against the risk of financial destitution as a result of having to pay for the care of an individual once they cannot function independently. Since this legislation makes a very good attempt at looking at ways that government and the private sector can both meet the long term care needs of the elderly, we ask that it be expanded to ensure that private sector insurance coverage is available, at an affordable rate, for those under 65, or not eligible for Medicaid.

Public/Private Sector Approach

The ARA believes that both the public and private sectors should have major roles in financing long term care. This approach fosters personal responsibility for dealing with the problems of illness and aging, but also improves the chances that those who are in need of care will be able to obtain it. We agree with the concept that neither the public nor the private sector can be expected to carry the full responsibility of paying for long term care, and applaud the incorporation of this concept into legislation. We believe that any program established should present a variety of options to pay for long term care. These may include the elimination of the $45,000-a-year cap on annual wages subject to the Medicare payroll tax, an increase in the basic Medicare premium, a supplemental income-based premium, and a federal surtax on gifts or inheritance of some assets, as provided for in S. 2305. In addition, other options, such as tax credits, tax deferred interest on insurance premiums, medical IRAs, among others, should also be considered. We should also be looking at ways that government can provide such options. State as well as federal participation should be encouraged.

A key element of S.2305 requires a two-year exclusionary period before Medicare begins to pay for nursing home benefits. The ARA believes that the concept of reducing the time for which an individual would need private insurance to help make it affordable is a good one. Given that the majority of nursing home stays (72 %) are under two years, we believe that the two year exclusionary period should be reduced.

The Role of Private Health Insurance

The success of a joint private and public sector approach to financing long term care will depend on the response of the private insurance industry and its ability to design and market affordable insurance policies.

The ARA believes that safeguards must be put in place to avoid the proliferation of policies claiming to provide long term care benefits, but in actuality having so many loopholes and exclusions as to make them useless. In May of this year, Consumer Reports magazine published an indepth evaluation of existing private long term care policies. Of the 53 policies they looked at, all were considered to have at least one major flaw. Some of the problems cited were:

- Persons with pre-existing health problems were often denied coverage, or waivers for pre-existing conditions were included in the policies. This is a critical problem for people with rheumatic disorders which may be chronic and progessive. Serious functional impairment may not occur until after many years. Such people would be denied benefits by these exclusionary policies.

- The policies are expensive.

- Some only cover skilled and intermediate nursing care -- not custodial care that is commonly needed and very expensive.

- Almost three quarters of the policies required prior hospitalization before any benefit could be provided. This is in the face of statistics that show that sixty-one percent of patients enter nursing homes without being hospitalized. Congress, by eliminating pre-hospitalization requirements in the catastrophic health insurance legislation has rectified this situation for current Medicare benefits. It is vital for private long term care insurance to also recognize this. Patients with progressive, chronic diseases such as arthritis, do not, as a matter of course suffer acute episodes requiring hospitalization prior to the need for admission to a nursing home. The ARA believes that patients with rheumatic and musculoskeletal diseases should have equal access to currently available chronic care to meet their specific needs.

- Very few policies had protection against inflation, thereby eroding the value of the policy over time.

Another conclusion drawn by Consumer Reports is that the variation in policy options is overwhelming to the average consumer, and denies the consumer the opportunity to effectively compare the merits of alternative policies. We have seen this type of problem before. This Committee is well aware of the problems associated with the provision of medigap coverage -- and the unnecessary costs expended by the elderly in the mistaken belief that the policy purchased will provide the coverage needed. Safeguards must be established and consumers must be educated as to the limitations of coverage. The federal government and states should play an important role in regulating the insurance industry to assure appropriate standards of coverage, the establishment of guidelines for proper disclosure, protections against sales abuses, regulation of requirements of renewal and cancellation, requirements for sufficient reserves, and the development of benefit/premium ratios.

Creation of Consumer Demand or Private Insurance Policies

The ARA believes that any legislation that comes out of this Committee should provide for consumer education programs. To create a truly useful and workable program to meet the long term care needs of this nation, there needs to be a market of purchasers of the private insurance policies that we desire to proliferate. Consumer education programs should emphasize the need for pre-funding anticipated costs of long term care needs. Consumer participation in private financing of long term care should be encouraged through a variety of modifications to the tax law. Mechanisms should be developed to encourage individuals to purchase long term care insurance, as well as for employers to offer such policies as part of employee benefit packages. The ARA would support changes to S. 2305 to accomplish this goal.

In conclusion, the ARA believes that the sponsors of this bill have made an important start on the road to development of a valuable national program to provide for the long term needs of the elderly and poor. We support the bill's emphasis on a mix of public and private sector approaches to the financing of such care and the inclusion of custodial and respite care as long term care needs. We encourage this Committee to revise the bill to include persons of all ages with chronic illness, and to put into place provisions for consumer information programs, and quality safeguards to regulate the desired proliferation of private long term care insurance policies.

TESTIMONY

of

BLUE CROSS AND BLUE SHIELD OF THE ROCHESTER AREA

and the

FINGER LAKES LONG TERM CARE INSURANCE COMPANY

by

HOWARD BERMAN

PRESIDENT AND CHIEF EXECUTIVE OFFICER

Thank you for the opportunity to submit a statement on a topic as important as long-term care.

My name is Howard Berman. I am the president and chief executive officer of Blue Cross and Blue Shield of the Rochester area and its subsidiary, the Finger Lakes Long Term Care Insurance Company.

Our corporations have been providing health care coverage for more than 50 years. In keeping pace with consumer needs, we introduced a long-term care insurance policy in November, 1987.

In my testimony, I will discuss our general support for S.2305. I will also review possible criteria for qualifying long-term care policies to receive tax-favored treatments; additional incentives to encourage groups and individuals to purchase policies; and other possible actions the government can take to facilitate the development and sale of long-term care policies. My testimony concludes with a summary of Blue Cross and Blue Shield of the Rochester area's activity in selling long-term care insurance.

We applaud S.2305 as the beginning of a workable solution to the long-term care financing problem.

In particular, we support the benefit design which includes:

- Coverage of custodial long-term care.
- Service coverage in a wide range of long-term care settings, and most notably, care in the home.
- Coverage of home or community-based respite care.
- Benefits paid in full when combined with beneficiary coinsurance.
- Eligibility review organizations.

As a private insurer, we agree with the contention that this bill should promote the development of private long-term care insurance. Blue Cross and Blue Shield of the Rochester area is committed to developing policies that will supplement this federal plan---similar to the insurance plans that private insurers developed to supplement Medicare.

LONG-TERM CARE POLICY QUALIFICATION CRITERIA

We support the definition of "qualified long-term care insurance" in S.2305, including the provision that long-term care insurance policies be guaranteed renewable. However, we recommend that the definition be expanded to include additional requirements. These are:

- Policy Exclusions - Insurers should be required to provide for a minimum of two years of care. Qualified long-term care insurance policies should not be permitted to exclude coverage for such conditions as Alzheimer's Disease.

- Coverage for care in all settings - Policies should be required to cover custodial care in all settings in which it is currently provided. These include: state licensed nursing homes, hospitals, hospices, adult day health care centers, and non-institutional residences. This would allow for responsiveness to patient preferences, as well as maximum flexibility and cost-effectiveness in the development of long-term care service plans.

- Inflation protection - Costs have risen significantly over the past fifteen years. A year in a nursing home now averages

$22,000. In another fifteen years, a year in a nursing home could cost more than $70,000. Obviously, coverage purchased today must have the same benefit value in the future. "Qualified" policies should provide coverage on a service benefit or a percentage of total expense basis. This will assure that the consumer receives inflation protection and has full knowledge of his copayment responsibility.

- Patient advocates - Expert guidance is needed so that the patient, family and physician work together to develop a plan of long-term care services that takes into account all available resources to meet a patient's individual health care needs. Through case management, the patient advocate can monitor the appropriateness of care plans and ensure that the needs of the individual are continuously met. All "qualified" policies should incorporate this type of beneficiary support.

The added features are important both to the real value of the insurance and to address the expressed needs of the elderly.

TAX INCENTIVES FOR THE PURCHASE OF LONG-TERM CARE INSURANCE

While S.2305 provides a number of valuable tax incentives for the purchase of private long-term care insurance, in order to successfully motivate consumers to purchase policies, additional tax incentives are needed for individuals, insurers and employees.

For individuals, the bill should include a waiver of Medicaid spend down requirements for holders of "qualified" policies.

For insurers, the bill should provide for the treatment for tax purposes of "qualified" long-term care insurance plans as non-cancellable accident and health insurance. This allows insurers to establish and build the reserves needed to fund future long-term care liabilities on a tax-favored basis. Reserves should be calculated using the "one-year full preliminary term" methodology instead of the current two year requirement. Under current law, insurers cannot establish tax-favored status for reserves for most types of health insurance until the policy has been in force for two years. Allowing tax free reserve build up after one year would help insurers to keep premiums as low as possible.

For employers, the bill should clarify that employer contributions towards long-term care insurance premiums are a deduction from current operating expenses.

FACILITATIVE ACTIONS

There are a number of actions which can also be taken to facilitate private sector initiatives in developing long-term care insurance. Provisions for the collection of long-term care data should be incorporated into any federal legislation addressing long-term care. Data regarding long-term care utilization patterns are essential to actuaries rating long-term care policies and health care professionals developing long-term care service programs. To establish a national data base, we recommend merging of files from Medicare, state Medicaid programs, the National Center for Health Statistics, and the National Home Care Association among others.

Pooling statistics allows private insurers to better predict their liabilities; this in turn should lead to more affordable private long-term care insurance.

SUMMARY OF BLUE CROSS AND BLUE SHIELD OF THE ROCHESTER AREA ACTIVITIES

We at Blue Cross and Blue Shield of the Rochester area have been responsive to these long-term care issues. We are one of the pioneers in the long-term care field and serve as a resource to organizations around the country.

The long-term care policy we developed is different from all others currently available in the nation.

The Blue Cross and Blue Shield of the Rochester area policy covers custodial care -- the service that is in greatest demand and which is not covered by acute care programs such as Medicare. Coverage is provided in a wide range of settings -- adult day health care centers, nursing homes and most importantly, in the home. Entitlement is based on an evaluation of cognitive and behavioral impairments as well as activities of daily living. Importantly, custodial care, regardless of its level of intensity, is covered. This means that custodial care provided in a skilled nursing facility, if needed, is a covered benefit.

The policy offers direct admissions to the care settings. In other words, no prior hospitalization is required for a nursing home stay and no prior nursing home stay is required for home care or adult day health care.

The program provides trained professionals to work with the individual and their families in developing an appropriate plan of care. These patient advocates help make arrangements for obtaining needed services. Because they can identify alternatives to nursing home care, they can help the policyholder remain at home, in familiar and psychologically comfortable surroundings when that plan of care is adequate.

The policy also provides coverage for "Respite Care," so that family caregivers can have up to 14 days of time off each year.

Additionally, the policy allows for retirement planning through variable payments terms, including 10 year and 20 year paid up options.

Protection against inflation is provided automatically. Blue Cross and Blue Shield of the Rochester area pays 75 percent of the cost of services -- not a fixed dollar amount. People have asked us: "What about the 25 percent policyholder copayment?" Our estimates indicate that this copayment can be paid using the Social Security benefits which an individual receives. Thus, the person's assets will be left, for the most part, intact.

To qualify for the policy, a person must be in reasonably good health for their age. Applicants must pass a medical screening test in order to be accepted. Once an applicant has been approved and has purchased the policy, their long-term care services are guaranteed. We do not exclude coverage for specific medical conditions, such as Alzheimer's disease.

We believe we have developed a long-term care policy that addresses several of the major concerns of the elderly: it provides coverage for care, which might otherwise impoverish them; it provides assistance in obtaining care, so they aren't faced with making these important decisions alone; and it provides coverage for alternatives to nursing home care, eliminating their concern of having to leave the familiar surroundings of their home.

While introducing such an innovative long-term care program is very gratifying, we are not resting on what we have done. We are in the process of developing a group insurance approach with local employers. A second generation of long-term care insurance offerings is also on our drawing board.

We acknowledge that no one has all the solutions to the financing of long-term care. Questions remain ... dealing with those currently ill and whether they can be grandfathered into new benefit packages. We applaud the introduction of S.2305 for it not only represents thoughtful and realistic progress on this issue but it also sets the stage for continuing discussion of how the public and private sector can forge ahead in a partnership to:

- Educate concerned individuals to the needs of the elderly ... the frail elderly as well as the sick. Unfortunately, the public perceives that Medicare and the recent catastrophic amendments offer long-term care protection; this misunderstanding must be corrected.
- Provide a source of insurance for the cost of long-term health care.

- Develop/implement methods to finance prolonged care.
- Assure access to and availability of long-term care services.

We must be flexible, innovative and responsive to a constantly changing long-term care environment. It is with this understanding that we support what you have done and call upon others to join you and us in settling this frontier in the financing of health care services.

TESTIMONY OF THE HONORABLE BILL GRADISON
BEFORE THE
HEALTH SUBCOMMITTEE OF THE SENATE COMMITTEE ON FINANCE
HEARING ON LONG-TERM CARE

Mr. Chairman, I want to congratulate you for conducting this hearing today and for the leadership you have shown in developing ideas in the area of long-term care. Survey after survey have shown that elderly Americans live in dread of becoming chronically ill and requiring the kind of support in daily living which only a nursing home or significant formal or informal home health care can provide. The elderly are afraid of the cost of this care but more particularly of the implications of losing control over their own lives. It is tragic in our society that all too often they must lose that control and lose their dignity as well.

Mr. Chairman, you have one of the most significant proposals on the table expanding Medicare to cover long-term care. Currently, there are over 50 bills from the House and Senate with varying public and private sector initiatives.

It appears the Congress has a great interest in moving in this area. But as we have learned over the years with medicare, social insurance is a complicated area and requires a great deal of work to structure appropriately. It has taken us over a year to develop the catastrophic legislation which truly enhances the insurance protection value of medicare. We cannot take the move to long-term care lightly. It will take time -- probably more time even than catastrophic -- to do it right.

I mention the need for this extensive effort because I know my colleague in the House, Representative Pepper, who is testifying today, will argue for his bill, H.R. 3436, which will be considered by the full House in the next few weeks. To be blunt, this bill has a lot of problems and I hope my colleagues in the House will send it back to the committees of jurisdiction rather than pass it on the floor.

I have a great deal of respect for Mr. Pepper and know how committed he is to long-term care for the elderly, but in this case, his proposal falls short. First, his bill is a home health bill and ignores nursing home coverage. Although they clearly are aware of the need for health care in the home, I think most elderly probably fear even more the prospects of $22-25,000 a year expenditures for nursing home care. Research has indicated that home care can make significant differences in the quality of life for the chronically ill, but it will not prevent very many home admissions. It is not, experts agree, a substitute for nursing home care.

Second, the Pepper bill approach ignores the catastrophic principal. Rather, it provides first dollar coverage for benefits. We have seen in the other entitlements under medicare -- Parts A and B -- the dilemma we face when we take a first dollar approach versus catastrophic. Also, this approach, particularly as it is carried over to the nursing home side, would place all the cost on the federal treasury and foreclose incentives for the elderly to fund their needs through private insurance or savings.

Since the Social Security Amendments of 1983, the Congress has moved toward the principle that those who benefit should share the cost of these benefits. The medicare catastrophic bill goes even further than the social security amendments. In the catastrophic bill, the elderly pay for their new benefits and the financing is geared significantly to income so that those who can afford the cost pay more. Clearly, we as a society have to protect the poor and near poor but those who have the ability to pay ought to do so. That principle is ignored in the approach taken by Mr. Pepper.

Finally, I understand that the Pepper bill is considered budget neutral. This is true to the extent that as revenues fall short, the Secretary of Health and Human Services has the authority to reduce the payments to providers or apply cost sharing. The Congressional Budget Office estimates of the Pepper bill indicate that in 1993, the bill will fall more than $500 million short so that the Secretary would have to take some action. Presumably, in the years beyond those for which CBO can project, the growth in the benefit would continue to be even greater than the expansion of revenues so that either the benefits would suffer significantly or Congress would be forced to find other funding sources to sustain the level of benefits.

This is no way to start out a new program. The Congress needs to address long-term care and I believe that process has begun in the appropriate fashion. Senator Mitchell, your bill is an important part of that process. Mr. Pepper's bill can be also, but it needs first to go through the rigors of hearings and committee action and consideration of alternatives. From this process will come the kind of program in long-term care that we can live with and that will truly provide protection from what the elderly fear the most.

STATEMENT

Submitted by

The National Association of Rehabilitation Facilities

Mr. Chairman:

This statement is submitted on behalf of the National Association of Rehabilitation Facilities. NARF is the national organization of community-based rehabilitation facilities serving over 600,000 persons with disabilities annually. Our membership includes freestanding rehabilitation hospitals, rehabilitation units of general hospitals, comprehensive outpatient rehabilitation facilities, home health agencies, skilled nursing facilities, transitional living centers and vocational facilities. Most, if not all, of our medical membership participate in the Medicare and Medicaid programs.

We commend the Chairman for introducing S.2305, the Long-Term Care Assistance Act of 1988, and its recognition of the need for long-term care assistance for many of the nation's elderly. This statement addresses general concerns regarding long-term care and makes some specific comments regarding S.2305.

I. THE PROBLEM

Existing health coverage of an illness or injury requiring care beyond the acute care hospital often does not address all needs for rehabilitation services. While the majority of Americans have some form of health insurance, this coverage is often limited, in terms of maximum dollar expenditures and/or limited in the scope or coverage of services. A patient requiring rehabilitation may exhaust this insurance coverage or the policy may exclude rehabilitation. In either event the patient is faced with the financial responsibility for the services and, if unable to pay, the facility is faced with the grim decision of providing the services free at a reduced rate or not providing them. From a recent survey of NARF members, we have found that the vast majority, primarily the non-profit respondents, experience an average 5% charity care and 4% bad debts out of their total annual budgets, but under increasingly more stringent financial circumstances.

The Committee has heard ample testimony on the demographics facing this nation. People are simply living longer. Twenty percent of the population will be over 85 years old by the year 2010. As noted in the recent report, Caring for the Disabled Elderly, Who Will Pay?, most older people remain physically active and capable of caring for themselves. Only one-quarter of Americans over age 65 in 1985 (6.3 million) were disabled. Of this group, 2.6 million were severely disabled. However, the prevalence of disability increases considerably with age.

Another group in need of long-term care services are the non-elderly with disabilities who comprise a large percentage of this nation's 36 million persons with disabilities. As medical technology has increased the ability to save lives, the issue then becomes what quality of life and with what dignity will these people be able to live it. For the young who incur disabilities and who then become old, as well as older people with disabilities, the need for long-term care occurs long before age 65, 75, or 85.

The Committee also has heard extensive coverage in its hearings held in 1987 on the problems of the existing Federal programs and lack of coverage of long-term care services and long-term care rehabilitation services. Since that time the Secretary of HHS's Task Force on Long-Term Health Care Policies has issued its report and the Brookings Institution has issued its new extensive report, all focused on the issue of how to provide long-term care. These studies highlight several features. They are:

1. The elderly and non-elderly disabled prefer to remain in their own homes as long as possible and be cared for by relatives. Only about 21% of the disabled elderly were in nursing homes in 1985.

2. The vast majority, nearly 90% according to Brookings, of those who are not in nursing homes, received assistance from relatives and friends sometimes supplemented by paid services. Studies have shown that usually these caregivers are female--the wives, daughters, or daughters-in-law. The personal, emotional and financial costs to the family and other friends and relatives in making this care is sometimes astronomical.

NARF's testimony last year highlighted the problems that exist with respect to rehabilitation coverage under commercial health insurance as well as the basic lack of coverage under Medicare and Medicaid. We noted the series carried by The Washington Post on the experience of a Virginia family when their 20 year old son was in an automobile accident and suffered severe head injuries. These series of articles highlighted the emotion, time and money which a family experiences when a member suffers a catastrophic illness and will probably require long-term care. Frequently, if not inevitably, the people who need the care are not able to get it because there is no one to pay for it.

The first objective in the area of long-term care is to avoid it. The nation's focus should be on reducing dependency and allowing people to maintain themselves in their own homes. In many cases, rehabilitation is the key for doing this. Therefore, in looking at the requirements for long-term care, NARF recommends that this Committee first look at providing adequate rehabilitation services as a way of avoiding permanent custodial costs.

II. MEDICAL REHABILITATION AND THE LONG-TERM REHABILITATION PATIENT

The goals of rehabilitation is to restore patients to their optimal functioning and thereby reduce dependency. Nonetheless, many rehabilitation patients, particularly (but not exclusively) the elderly, require continuing care services following or in support of the care rendered in rehabilitation facilities. Rehabilitation facilities and professionals often face very hard choices in dealing with the needs of their patients because they need long-term rehabilitation services and, because of the lack of coverage for such services. Current proposals on long-term care begin to address this issue.

Rehabilitation facilities and professionals serve people suffering from major illnesses or the results of accidents. For example, there are over 10,000 people with spinal cord injuries per year and the majority are the result of automobile accidents. There are between 700,000 and 900,000 head-injured people per year of which at least 10% (70,000) are considered severely traumatically brain injured. Of these over approximately 50% are the result of automobile accidents.

Rehabilitation specialists also treat the elderly who suffer from strokes, arthritis, hip fractures, heart attacks, pulmonary and cardiovascular diseases, and neurological and musculoskeletal diseases. These individuals require extensive services both from the time of the injury or illness, frequently through outpatient care, home health, adult day health care, residential living care and, in some cases, continued support on a daily basis. These programs have significant costs attached to them. As a result, facility administrators and financial officers face the personal, emotional, and financial trauma that occurs when our existing health care payment system does not help these special patients. These patients include the elderly, as well as non-elderly with disabilities.

Rehabilitation integrates medical and social services. There are over 500 rehabilitation hospitals and units, 150 comprehensive outpatient rehabilitation facilities, 900 rehabilitation agencies and other outpatient providers and numerous home health agencies providing rehabilitation services throughout the country.

The primary function of such facilities is to provide diagnosis and treatment of patients for specified medical conditions both surgical and non-surgical. The average length of stay in a rehabilitation hospital or unit is longer than in the acute care setting because the objective is restoration of impaired functions which follow serious disease or injury. The ultimate objective of rehabilitation is functional independence. Once a patient is released, many require outpatient and home care services. Rehabilitation can minimize the need for institutionally based long-term care, although some people with disabilities require continuing institutionalization when home and community care is inadequate.

While the emotional benefit of personal independence may not be measured in dollars, psychological, physical and financial independence can. Recent studies of rehabilitation patients who are medically and vocationally rehabilitated show that for every federal dollar invested, the person's earnings increases $10 per hour. Cost studies of stroke rehabilitation also show considerable return on the investment in services. A person who is not rehabilitated costs $92,736 in 1980 dollars more to support than a rehabilitated patient living at home. The average cost for a stroke rehabilitation program is $8,000 to $11,500 in 1980 dollars. This results in average savings of $81,250 to $84,740 again in 1980 dollars. More recent studies by the Health Insurance Association of America show that for every $1 spent on rehabilitation, $11 was saved in other benefits that would have been paid. Also, an INA study in 1981 concluded that in long-term disability cases, for every $1 spent on rehabilitation $17 is saved. Rehabilitation thus should be a cornerstone of a long-term care policy.

III. RECOMMENDATIONS

NARF commends this Committee and the Chairman for moving away from the institutional bias for long-term care services. NARF supports having services that can be delivered at home or through community-based organizations such as rehabilitation facilities, thereby allowing people to live in as independent a setting as possible. This is simply the more preferable alternative for most individuals. To this end, NARF has the following specific comments on S.2305 and general comments.

A. S.2305

NARF commends the Chairman for the considerable effort involved in drafting the bill. Our specific comments follow:

1. Section 101, page 8, we recommend adding "transferring to tub and/or shower" to the list of activities of daily living that would be examined to determine if someone is eligible to receive chronic home care services. Rehabilitation professionals have considerable experience in conducting rehabilitation evaluations which focus on assessing an individual's ability to perform activities of daily living. Included in the typical evaluation is an evaluation of the individual's

ability to transfer in and out of the tub and toilet, usually a very hazardous area.

2. NARF appreciates the interest in a managed care approach, however, caution that it not be used solely to contain costs. The current experience of rehabilitation facilities with many HMO plans is that they simply do not provide coverage for rehabilitation services although generally required to do so. The individual is left in a dependent state, and constantly readmitted to the hospital setting for more acute care. This is short-sighted.

3. NARF would recommend that before an individual is deemed to be eligible for chronic nursing home services (Section 102, pages 24-25) that in the eligibility section (page 24), the individual be fully evaluated by rehabilitation professionals for rehabilitation potential. Each person referred for chronic nursing home services would have a rehabilitation evaluation prior to placement for such services. Early rehabilitation can prevent or at a minimum reduce long-term care needs, thereby either preventing placement in a nursing home and dependency in areas of activities of daily living or improving the level of functioning in activities of daily living and reducing the need for certain services once in the nursing home.

   We would also recommend that a similar change be made for the Medicaid program. Such an evaluation may prove to be a great cost saving under the proposed S.2305 for states which are spending close to 45% of their Medicaid dollars for nursing home care. If an individual is deemed to have rehabilitation potential he/she should then be referred to the appropriate rehabilitation facility, hospital or unit to receive a comprehensive rehabilitation program.

4. In Section 301, pages 73-74, pertaining to long-term care insurance, NARF concurs that long-term care services must recognize the role that rehabilitation plays in the prevention of disabilities as well as maintenance of current health status. We also concur with the definition of those facilities that are qualified to participate.

5. In Section 301, page 75, for the definition of "chronically-ill individual" we recommend adding locomotion (by walking or wheelchair), communication and possibly cognition to the list of activities. If a person is not able to communicate, he or she usually needs assistance in making his or her needs known to the outside world. Additionally, if a person is cognitively impaired, personal safety and ability to make judgments regarding personal safety may likewise be considerably impaired.

B. General Comments

Several guidelines should be included in any final proposal:

1. The objective of any long-term care program should be to allow the disabled elderly or non-elderly disabled to continue to live a life of dignity and at the highest quality with an emphasis on independence, autonomy and responsibility.

2. Support from the family and other informal systems should be encouraged but not pushed beyond reasonable limits. For example, the health of an overburdened family member should not be jeopardized.

3. Benefits should cover a comprehensive, defined spectrum of appropriate medical, including rehabilitation, and social services, both institutional and community- or home-based, without financial bias in any direction.

4. Continuity of care and records and appropriate use of services must be ensured with protection for the patient against being given substandard care as part of an effort to control costs.

5. A health data base should be established for each participant. Each person should have initial and periodically reviewed multidisciplinary evaluation of medical and functional status, i.e., abilities to perform all tasks of daily living at the time of application for benefits to help in determining eligibility, therapy and placement.

6. Financing must be adequate to the task. Good long-term care, like good short-term care, will not be cheap. Inadequate funding will kill the program. It should be based on risk pooling through a combination of insurance and taxation, as well as an appropriate amount of cost sharing by the patient or family.

C. Coverage

Any final bill reported by the Committee should recognize and cover the complete spectrum of the patient's long-term rehabilitation needs. People who do not receive such services deteriorate and often end up being readmitted to a hospital or a nursing home. This is simply a waste of time, tax payer or insurance money if, with a bit of foresight, such a situation can be prevented. This continuum of coverage should be in addition to rather than in replacement of existing benefits and not used as a trade-off for or limitation on other benefits. Such benefits should assume coverage of services offered under Part A and Part B of Medicare as a starting point for the basic package of rehabilitation services.

In addition the bill should provide for the long-term care needs of rehabilitation patients by expanding services such as respite, adult day, home health aide, and psychosocial rehabilitation services. NARF members who currently run adult day rehabilitation programs note the cost of such programs is a considerable savings over the cost of a skilled nursing facility ($58,400 average versus $12,500 in New York City) -- almost a five to one savings. We also would urge the Committee to look into such issues as nutrition, transportation, and housing, particularly for the non-elderly with disabilities. Finally, existing exclusions in commercial insurance for rehabilitation services or rehabilitation sites should be eliminated. S.2305 starts in this direction.

D. Populations

Any final recommendation from the Committee should assure coverage of the long-term care needs for all populations including the non-disabled elderly and elderly, as well as the potential long-term care needs of the poor, working poor, unemployed and employed.

E. Financing Mechanisms

The major stumbling block in the discussion of how to provide needed services, is how to finance them without impoverishing the Federal Government, private insurers, estates, and individuals.

NARF believes that a combined public and private sector approach is the most reasoned one. This is contemplated in part in the Brookings study. It does have the draw back, however, of being economically determined, usually by income and/or employment status.

If public financing is to be addressed in addition to the discussion on tax incentives and premiums, NARF would recommend adding excise or use taxes. For example, HHS Secretary Bowen in his proposal has suggested that catastrophic health insurance be required of anyone registering a motor vehicle. We would suggest that a true definition of catastrophic health needs and expenses includes long-term care needs and that other sources of financing be examined. Motor vehicle accidents are highly correlated with injuries such as spinal cord and head injuries, known to result frequently in long-term care needs. Perhaps there could be an increase in the gasoline tax with a percentage dedicated to reducing the deficit and another percentage of the tax dedicated to a fund to pay for the long-term rehabilitation needs of those suffering from the results of car accidents.

To the extent Congress takes legislative action, to stimulate private long-term care insurance, NARF would recommend that the legislation provide for the establishment of standards relative to the clear statement of benefits covered and excluded. S.2305 is a step in this direction.

Comments Submitted to: The Health Subcommittee of the Senate Finance Committee

By: Commissioner Sandra S. Gardebring
Minnesota Department of Human Services

Minnesota has long enjoyed a reputation as an innovator in the area of long term care for our elderly citizens. As our population ages and the number of elderly needing long term care services increases, costs will rise accordingly. We are concerned about the fiscal impact of this trend on state and federal budgets. One of the few alternatives that can ease this burden is private or government sponsored insurance coverage for long term care. Current research by Brookings/ICF indicates that by the year 2018 private insurance may be affordable by 26 - 45 percent of the elderly, may account for 7 - 12 percent of total nursing home expenditures and may reduce Medicaid costs by only 2 - 5 percent. Clearly private insurance is only a partial answer to funding long term care.

Various forms of long term care insurance have been marketed in conjunction with "Medigap" policies for a number of years. The biggest problem with these policies is that they have paid for very little care. This is mainly because of language in the policies that ties the insurance coverage to the Medicare definitions of skilled nursing care which are extremely stringent and exclude certain types of illness and/or require hospitalization prior to nursing home admission. Furthermore, such policies have provided little if any services in the policy holder's own home.

The recently passed catastrophic health care bill eased some of these restrictions, but even after these changes, Medicare will pay for relatively little of the high cost of long term care for our elderly citizens.

Private long term care insurance is beyond the financial means of many of those elderly who need it most. Therefore, we believe that ultimately a national publicly financed long term care insurance strategy should be pursued.

The financial risk of long term care should be pooled across a broader population, not just those who are currently using long term care services. This is one of the many positive features of S. 2305.

Although S. 2305 goes a long way toward addressing the above issues, I do have a number of concerns about this legislation:

1. The two year exclusionary period and 30% copayment are still beyond the means of a large portion of our current population using long term care services.

2. The effect of this proposal on state medicaid expenditures is at present unclear. However, given the two year exclusionary period and the 30% copayment, it appears that there will still be the need for significant medical assistance funding by individual states. It is imperative that the current federal financial participation rate be maintained for the ongoing Medicaid expenditures for nursing home care if this new program is implemented.

   Minnesota has a strong commitment to quality long term care services for all its' citizens. We have demonstrated this by our high level of financial support for long term care services. Any new program must be designed keeping in mind the fact that state governments have a very limited ability to absorb any incremental increase in costs that may result from the implementation of new federal programs. States that have demonstrated a willingness to provide quality services should not be "penalized" financially for being on the vanguard of meeting the long term care needs of their senior citizens.

3. At present, there are 50 states and 50 different systems for setting provider payment rates. How payment rates would be established under the bill is unclear. Careful consideration must be given to the systems that exist because each state approaches the process differently based on their own labor costs and policy objectives. Minnesota did extensive research and expended significant resources developing a case mix system that has been used as a model in other states. It is important that these innovative systems which both target resources and control costs, continue in the future.

4. State administration of long term care services is another subject that must be addressed. The proposal presented, gave no indication of what the role of the state would be if this bill is passed. States have been the major actors in the long term care field, filling the void created by absence of a true national policy. The valuable experience that states have in administering long term care programs and policies should not be wasted. We feel it is vital that states maintain control of program administration. This would insure that the needs of our elderly are met at a reasonable cost.

5. A very important provision of this bill is that it does support the use of private long term care insurance as a method of paying for care during the exclusionary period. This could provide a continued incentive for the purchase of private long term care insurance and may reduce the burden on the Medicaid program during the exclusionary period for certain individuals. However, it appears that this bill will function in many instances as a stop loss program for insurers. Given the high copayment and lengthy exclusionary period, it is likely that those individuals with the greatest need will receive few if any of the benefits available under this program.

   In addition, many long term care insurance products do not meet minimum standards required to truly protect consumers even in the first two years of need. It is my belief that the following are essential criteria of any long term care insurance product designed to cover long term care, if the policy is to be effective for the consumer, and in reducing state and federal long term care costs:

   a. No hospitalization requirement.
   b. Reasonable deductibles.
   c. Premiums that are affordable to persons on a fixed income.
   d. Coverage for home care.
   e. Coverage should be indexed for inflation.

   Until these elements are addressed as part of every long term care insurance policy, Medicaid will continue to be a major payor for those who fall through the cracks duri the exclusionary period.

There is a great deal of research being conducted on the best design for a publicly financed national long term care insurance system by organizations such as the American Association of Retired Persons (A.A.R.P.) and the Villers foundation. These efforts may result in additional approaches which should be considered in solving this very important problem.

This legislation provides an excellent opportunity to begin discussion. However, I feel that we should further explore the A.A.R.P./Villers proposals now being developed if we are going to make substantial progress toward eliminating impoverishment of the elderly. We look forward to continued debate about how best to finance long term care services to our elderly and disabled citizens.

STATEMENT OF
FORMER CONGRESSMAN JAMES ROOSEVELT
CHAIRMAN OF
THE NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

My name is James Roosevelt and, as chairman of the National Committee to Preserve Social Security and Medicare, I represent more than five million seniors with a deep, vested interest in long-term care. Our members are prolific writers, and remind us daily through their powerful and often devastating letters about the catastrophic flaws in our health care system.

Mr. Chairman, on behalf of the National Committee's members, I want to commend you on your leadership in setting forth a constructive legislative proposal to address the needs of seniors who experience the catastrophic cost of long-term illness. Comprehensive coverage which includes home health care, respite services and institutional care makes S. 2305 a far-reaching and important instrument for shaping a long-term care policy for this nation.

I hope S. 2305 will receive prompt and positive attention from your colleagues in Congress. The sooner S. 2305 passes, the sooner people such as 84-year old Carrie Moore of Rome, Georgia, and her 86-year-old sister who suffers from Alzheimer's disease will receive long-term care. Ms. Moore writes: "More than two years ago I took (my sister) into my home to protect her from the severe winter weather. . . She must not be alone more than ten minutes - doctor's orders. She has to be bathed, dresssed and led to bed. Often I am awake all night and sleep only while she naps a bit during the day. On February 23, as I rushed to complete the early morning chores, I fell and cracked an ankle bone. . . I must pay a volunteer to live in and care for us. The drain on my dwindling savings seems awful; but what can I do? We can adjust to a handful of crackers and a glass of milk for a meal; but medicine doesn't come cheap."

Another example of the desperate need for long-term care is a 76-year-old man, Mr. Michael DeLoia from Hopedale, Massachusetts, who is caring for his 69-year old wife, a stroke victim: "The stroke blew a hole in her brain the size of a quarter, but after six months in a nursing home I had her brought home. I gave up my salesman's job just to care and watch over her; now I have been caring for her for 12 years. I had Medicare, but that wasn't enough and I spent all my life's savings to do all I could to help her recover. . . I need help to care for her. We live on a Social Security pension."

If unable to finish work on your complete bill this year, we would urge you to take a first step by passing a bill with home health care and respite care services. The House will soon consider long-term home health care legislation introduced by Representative Claude Pepper. This legislation, which in many ways is similar to the home care component of your legislation, has been introduced in the Senate by Senator Simon, an original cosponsor of your bill. This nation's current long-term care policy has a strong institutional bias. As a result, the nursing home industry is much more developed than the home health care industry. Putting a long-term home health care component into place first will make home health care more available to seniors who would prefer to stay at home.

PART ONE: BENEFITS

Care Management

Clearly, one of this country's most compelling social goals is to establish a comprehensive, coordinated policy on long-term care. S. 2305 points the way towards that goal by providing for Medicare coverage of an array of long-term care benefits coordinated through a system of care management. An effective care management system serves as a "gateway" to assure that only needed services are provided and that beneficiaries do not experience any gaps in services. The National Committee endorses the care management component of S. 2305 and recommends a further development and integration of this component of the legislation to reduce the bureaucratic layers and make the long-term care services more effective.

It is wise cost control to limit potential conflicts of interest by separating providers of direct services from care managers. The National Committee is concerned, however, that your legislation leaves room for the creation of separate structures for eligibility review and care management when ideally they should be integrated. Two structures not only establish another layer of bureaucracy for seniors to face, but also create an artificial division between the process of assessing an individual's needs to determine his eligibility and developing and managing a care plan based on that assessment. Another important benefit of combining eligibility determination and care management is that the eligibility decision would be based on a face-to-face multidisciplinary assessment rather than a paper review.

In addition, the National Committee recommends that you clarify that beneficiaries begin to receive care management as soon as a potential need for long-term care services is identified, even at the acute care stage. The need for care management should certainly be identified as part of the hospital discharge process. Care management should integrate current Medicare benefits for acute care with the proposed new long-term care benefits to eliminate gaps in coverage.

Another, more financial, reason for initiating care management and determining eligibility early is to establish that out-of-pocket long-term care costs would be Medicare-approved and apply towards the deductibles and be covered by private insurance. If an individual has no insurance and cannot afford to pay for long-term care, the care manager can also assist in applying for Medicaid or identifying other services or resources.

Eligibility

While other long-term care bills base eligibility primarily on the need for assistance in a number of activities of daily living (ADL), your legislation expands and refines the eligibility criteria to take into account individuals with dementia. Clearly, many individuals in the early and middle stages of Alzheimer's disease would not meet the ADL deficiency criteria and, yet, their families are in real need of assistance. Studies of families with dementia patients indicate the families' perceptions of their burden decreased over a two year span, even though the disease progressed and the patients' problems occurred as often as before. S. 2305 allows the family to get respite during the early stages when they are subject to severe stress. The National Committee specifically endorses this provision.

It is estimated that between 100,000 and 200,000 children in need of long-term catastrophic care would not be covered under S. 2305. The National Committee recommends including children under S. 2305, because doing so would follow the general principle that Social Security and Medicare insure workers and their families for risks against which the private sector does not protect. The need for long-term care is not age-related, so excluding children from coverage would undermine the political support for the broad-based financing which is needed to finance long-term care.

Eligibility requirements in S. 2305 which limit the respite benefit to family members living with the disabled person should be expanded to apply to all primary caregivers. Between 80 and 90 percent of long-term care is provided by family and friends who have their own personal needs and family responsibilities. The 1982 Informal Caregiver Survey of the National Long-Term Care Survey found that 26 percent of the 2.2 million caregivers in this country did not live with the disabled person. Yet we know, it can be just as exhausting for a caregiver to run between his or her own home and the home of the disabled person several times a day to make sure that adequate care is provided.

This situation was powerfully illustrated in a recent nationwide video teleconference on "Aging in America: Dignity or Despair." At 250 sites across the country, 50,000 people watched a documentary of a young woman who spends all her waking hours away from her own family taking care of her father in his home. At night, after a long day at work, her brother relieves her so that she can go home to her young children and husband. This family would greatly benefit from respite care, but would not be eligible under your bill because they maintain separate addresses. This restriction in your bill is unnecessary, because the already strict requirement for care would prevent overutilization. A person with two or more deficiencies in daily living, by definition, requires caregivers whether or not they actually live under the same roof.

Deductibles and Copayments

The National Committee is concerned that the deductibles and copayments for the home health and nursing home benefit are much too high for many seniors. One must question how many seniors will actually benefit from the nursing home reimbursement which requires a two-year waiting period. Well-publicized studies released by the House Select Committee on Aging found that almost half of couples with one spouse in a nursing home reach poverty within 13 weeks and around 80 percent of couples do so within one year. About 70 percent of individuals reach poverty within 13 weeks of a nursing home stay and more than 95 percent of singles go broke within one year. Few people have $50,000 life-time savings - - yet they'd need that much to pay the cost of a two-year stay in a nursing home, prior to the time Medicare would begin to reimburse nursing home care. The cost of private insurance would also be expensive. Considering the above, the National Committee believes that the waiting period should be no longer than a year.

We also urge you to allow families to supplement the home care benefit with their own resources if the dependent senior needs more care than permitted under the home care cost containment cap. The current Medicare home health benefit does not allow private supplementation.

At the same time, we applaud the Chairman for protecting seniors from the additional out-of-pocket cost resulting from balance billing. S. 2305 requires that cost of services be set according to a fee schedule which eliminates the serious problem of providers charging beneficiaries large sums in addition to the copayment. This removes the fear and unpredictability of balance billing which this year alone is estimated to cost seniors $3 billion.

PART TWO: INTEGRATION WITH PRIVATE INSURANCE

The National Committee endorses the concept of a public/private partnership providing protection from a catastrophic long-term illness. However, the success of your legislation in providing adequate protection for long-term care depends on insurance companies offering affordable policies to cover the deductibles and copayments envisioned in your legislation. Without affordable private insurance, the vast majority of seniors could not handle the nursing home deductible without going bankrupt, thereby defeating one of the main purposes of this legislation.

The Brookings Institution estimates that 70 percent of the elderly could afford a currently available private insurance policy covering the two year nursing home deductible without spending more than five percent of their income. Another 12 percent of seniors have incomes below the poverty line, and under your legislation, would be covered by Medicaid. This leaves another 18 percent of seniors -- 4.8 million -- who would still have inadequate coverage for a long-term care illness.

The policy that Brookings used in its study cost $470 a year in premiums at age 65, but it did not provide indexed benefits and had many restrictions. The Social Security Administration (SSA) has estimated that a fully indexed policy, without all the exclusions of currently available policies, would cost $647 a year. Less than 50 percent of seniors could afford this. The National Committee would prefer a waiting period at shorter duration so that 80 to 90 percent of seniors could afford private insurance. Annual premiums for a one year policy would be $362 a year according to SSA. Such a policy would be affordable for seniors with incomes over $7,500 a year.

While the largest out-of-pocket costs would be related to the deductible and copayment for nursing home care, your legislation envisions additional deductibles and copayments for the home health and respite care component. It is not clear that private insurance companies would offer policies to pay these deductibles and copayments. In testimony to the Ways and Means Health Subcommittee last year, the Brookings Institution warned that insurers try to protect themselves from increased demand and utilization by using high deductibles and by limiting coverage to nursing home care. If this proves to be true, the National Committee would urge you to eliminate the deductibles and copayments for home health care and reduce or eliminate them for respite care.

A key element to stimulating private insurance coverage is Medicare's role in determining eligibility. As recommended in part one, Medicare will need to determine immediately that expenses related to long-term care services are necessary and will be applied toward the appropriate deductibles. Private insurance coverage will be much more economical if it is also geared to Medicare-approved long-term care services.

The National Committee supports provisions of S. 2305 which clarify the tax treatment of long-term care insurance. Clarification of tax treatment is necessary to stimulate private long-term care insurance. At the same time, S. 2305 should anticipate the need for a regulatory framework to protect the consumer. A recent Consumer Reports analysis of 53 long-term care policies pointed out serious flaws in most of the products currently being offered on the insurance market. Many policies have no inflation adjustment on benefits, a failure which makes such policies almost worthless for individuals under age 60 who are not expecting to need long-term care for years to come. Another problem is the exclusion of Alzheimer victims in many policies. The requirement that coverage in a nursing home has to be preceded by a hospital stay eliminates most dementia patients as well as other patients suffering chronic conditions not requiring acute attention. Some states have banned the prior hospitalization feature.

To leave the design and marketing of insurance products entirely to insurance companies would invite abuses similar to those that occurred in the medigap insurance industry. These abuses spurred Congress to pass the Baucus amendment in 1980 establishing minimum coverage requirements, loss ratios and marketing restrictions. The National Committee recommends that Congress pass similar regulations for long-term care private insurance.

PART THREE: FINANCING

Mr. Chairman, the National Committee wants to commend you for putting forward a financing proposal consistent with social insurance financing principles. To be affordable, the financing must be broad-based, as it is in your legislation. Expanding on the "user fee" approach found in the pending catastrophic legislation would have been a mistake.

Any long-term care legislation with adequate coverage will have a large price tag, but a political consensus is developing which will accept the necessary taxes, especially the elimination of the wage base cap on the Medicare portion of the payroll tax. The public recognizes that a public insurance program would replace private spending and relieve families of the emotional and financial stress.

The National Committee supports in principle the idea that seniors should contribute to part of the cost of expanded Medicare coverage, up to 25 percent of the cost. But if the catastrophic health insurance bill passes with 100 percent of the cost financed by seniors, the National Committee would not support any further increase in Medicare premiums to pay for long-term care. While S. 2305 would cost approximately $14 billion a year, seniors could still be responsible for another $10-15 billion a year in deductibles and copayments. If the estate tax is increased to pay for long-term care, a substantial portion of this revenue will be generated from assets accumulated by seniors.

RECOMMENDATIONS

In summary, the National Committee urges you to consider the following recommendations:

- Combine assessment, eligibility determination, development of a care plan and care management into one service component.
- Integrate acute and long-term home health benefits by requiring assessment and care management at the acute care stage.
- Allow supplementation of services from private funds.
- Extend coverage to disabled children.
- Reduce the two-year exclusionary period before nursing home coverage becomes effective to no longer than one year.
- Allow the respite benefit to apply to caregivers who maintain a separate address.

- Require eligibility assessment at the onset of a nursing home stay.
- Assure minimum standards of long-term care private insurance policies.
- Limit beneficiaries' cost share to 25% of overall Medicare program costs (including changes made by the catastrophic legislation).

Conclusion

Mr. Chairman, we are prepared to work with you and your staff to develop this important legislation that would finally extend long-overdue true catastrophic protection against the cost of long-term care. America's seniors are counting on your leadership to find a way to meet the needs for long-term care.

PROCTER & GAMBLE
LONG TERM CARE INSURANCE PROGRAM

Procter & Gamble (P&G) introduced a Long Term Care Insurance Program to active employees in the fall of 1987. By making this benefit available, the Company has provided employees a way to insure against the potential significant financial burden of long term care needs for themselves, their spouses and parents.

The program is also currently being offered to most P&G retirees.

Description of Plan

Employees can participate in long term care through our flexible benefits program using after-tax dollars from Company credits, redirected salary and/or cash in-lieu-of vacation. Premiums can also be paid through payroll deduction. Because the likelihood of needing long term care assistance is higher as age increases, rates are based on age at the time of enrollment. However once a person is enrolled in the program, their premium cannot be increased based on solely age.

On January 1 following their employment date, employees can enroll themselves and their spouses without providing evidence of good health. Once participation is waived, employees and their spouses must provide evidence of good health to enroll in the program. Parents of employees and employees' spouses can enroll within 60 days of their children's first enrollment period, provided their children are participating in the plan. Parents must provide evidence of good health.

The program is designed to maximize flexibility in how long term care services can be provided, particularly in regards to home care. Home care services can be rendered in the participant's home, any private home, a facility for the retired or aged, an institution which provides residential or continuing care, or an adult day care center. Also, the lifetime benefit maximum of $109,500 can be used for any combination of home care or care at a nursing facility, which provides incentive to use the Home Care Services as long as possible. Benefits for care in a nursing facility are $60 per day, and $30 per day for home care.

Qualification to receive benefits is based on loss of functional capacity. If a participant is unable to perform 2 out of 5 basic activities of daily living (eating, toileting, dressing, walking or transferring) they are eligible to receive benefits. Loss of functional capacity can be a result of injury, illness or mental impairment due to a diagnosed organic condition such as Alzheimer's Disease. Hospitalization or prior confinement in a skilled nursing home are not necessary to qualify for any benefits provided by the Plan.

Other special provisions of the Plan include:

- Return of Premium
  Should a participant die without receiving more than 90 consecutive days of benefits, an amount equal to the total amount of all premium payments will be paid to the estate or premium payor.

- Portability to an Individual Policy
  In the event a participant is no longer eligible for P&G group coverage (e.g., termination, death of employee, divorce of spouse), the insurance company offers the opportunity to continue coverage in a community-rated plan.

- Extended Term of Coverage
  If a participant stops premium payments for any reason, coverage will be extended for a period of time, based on participant's age and length of participation. (e.g., if premium payments stop at age 50 after 10 years of participation, coverage will be extended until age 62).

More detailed information about the design of P&G's Long Term Care Insurance is included in the attached plan booklets.

Participation Data

As of June 1, 1988, 35,000 active employees had the opportunity to enroll in the Long Term Care program. Of the 35,000 employees eligible, 3250 (9.3%) elected to participate. Most participants are over age 40. Of our approximately 20,000 administrative, technical and managerial employees, 20% of all eligible employees over age 40 are participating in the program. About two-thirds of participating employees also enrolled their spouses, and over 360 parents have been enrolled.

The enrollment period for retirees ends July 1, 1988, and final enrollment data is not yet available.

Comments Regarding Proposed Legislation

The Long-term Care Bill proposed by Senator Mitchell relies heavily on deductibles, copayments and waiting periods. These provisions are intended to help control the cost of the program, and provide incentives for insurance companies and employers to make private coverage available. In a recent article, Senator Mitchell was quoted as saying "If private long-term care insurance becomes widely available at a reasonable cost, which I believe is likely with the two-year exclusionary period, this approach will be successful".

We believe strongly that the introduction of a major federal program, such as the one proposed by Senator Mitchell, would greatly reduce incentives for the private sector to make long-term care insurance available. We also believe that costs of a federal long-term care program would be better controlled by restricting who can collect benefits based on need, rather than creating a system of deductibles, co-payments and waiting periods in a program covering the general population.

The proposed program would inhibit the private sector from making long-term care widely available

The current qualification requirements to receive long-term care benefits under Medicaid have been a major reason many of our employees decided to participate in, and pay for, our program. If long-term care coverage is provided to all citizens through Medicare, regardless of financial status, the real and perceived need for private insurance will be dramatically reduced. Because many long-term care needs would be met through Medicare, employees would be much less inclined to purchase additional insurance of their own. While the provisions of the proposed legislation would leave a gap for private programs to fill, individuals would probably perceive that most of their long-term care needs will be met by the government (or, that they would find a way, with their own funds, to fill the two-year gap if it became necessary).

When we introduced long-term care insurance at Procter & Gamble, we were able to clearly communicate to employees that Medicaid only pays long-term expenses to those whose financial resources have been exhausted. Communicating the proposed provisions in Senator Mitchell's bill would not be a very compelling message for people to consider purchasing their own long-term care insurance.

As the need and motivation of individuals to purchase coverage is reduced, the availability of programs offered by employers and insurance companies would also be reduced. For example, if Senator Mitchell's bill had been passed last year, it is doubtful that Procter & Gamble would have introduced a program of our own. If we had to design a program which would supplement the proposed legislation, it is likely we would have determined that the limited value our program provided did not warrant the resources necessary to introduce and administer the plan. This, coupled with the fact that fewer employees would participate in the plan, would probably have resulted in a decision to not make long-term care insurance available to our employees.

A more important factor in making that decision, however, would have been our understanding of the government's intended role in providing long-term care. By making long-term care available to everyone, we could conclude that the government had assumed responsibility for providing this benefit. We would predict that the co-payment provisions would be made less restrictive over time, and our plan would continually need revisions to react to those changes. These changes would reduce the marginal value of our plan, making it less attractive for employees to participate in and for the Company to administer.

There are certain aspects of the proposed legislation that would provide positive incentives for the private sector to make long-term care insurance more widely available. These incentives generally involve the tax treatment of premiums and reserves for long-term care insurance. However, based on our experience and current situation, the net result of the proposed legislation would be contrary to its stated intentions. The incentive for employers to make long-term care programs available and for employees to participate would be significantly reduced.

The costs of a federal long-term care program would be controlled better by basing eligibility on financial need.

The primary benefit of most long-term care insurance programs, including Procter & Gamble's, is protection of financial resources; to prevent long-term care expenses from depleting a person's assets. This would also be the case with a federal program which is available to all individuals regardless of financial need. The Department of Health and Human Services estimates that within 20 years, ninety-three percent of elderly couples and 60% of single elderly individuals will be able to finance long-term care insurance with less than 5% of their income. Creating a major social program to preserve estates of the elderly seems questionable. The cost implications are obvious.

The funds required to provide benefits only to those in need are much less than a comprehensive program would require. There are also other important cost considerations. If the federal government assumes responsibility for providing long-term care benefits there will be little incentive for individuals, families and employers to find ways to effectively deal with this issue. The demand for the types of services provided through the government's program will increase significantly and, in turn, will cause costs to increase faster than normal. Increasing costs will also make private programs more expensive, reducing the number of people who can afford them.

Availability of a wide variety of options allows individuals to select alternatives that best meet their particular circumstances. Some plans, like Procter & Gamble's, are designed to maximize flexibility in terms of delivery of benefits, especially for home care services. Other policies may provide more basic coverage at less expense, and some people might determine they do not need insurance because of their financial situation or family support. The cost to the government, and society in general, are minimized by this approach, and needs are met more effectively.

Summary

We agree with Senator Mitchell's objectives of making affordable, long-term care insurance widely available and controlling overall cost. To do so, it is necessary to provide incentives for employers and insurance companies to develop and offer programs at competitive prices, and for individuals to participate in those programs. Establishing a federal long-term care insurance benefit that does not consider financial need will, in our view, work in direct opposition to providing the appropriate incentives needed to achieve these objectives.

"LONG-TERM CARE ASSISTANCE ACT"

Expansion on Medicare

submitted by

Valley Area Agency on Aging

June 21, 1988

Perhaps the two greatest concerns of the aging population in the United States are health and finances. With the introduction of Senate Bill 2305, Senator Mitchell should be congratulated on his efforts to address these concerns. The "Long-Term Care Assistance Act" provides a new Medicare benefit for long-term care.

This bill is an innovative attempt to feasibly expand the delivery of long-term care and to provide assistance in financing it. He does this by tapping into existing services or service models, while expanding them, where necessary, in the areas of funding and service delivery. This bill is not "the" answer, nor is it touted to be. Perceived assets and liabilities are as follows:

The bill does specify eligibility criteria. The criteria vary according to the service requested. Assessments and care planning will be carried out by required case management services. These specifications help ensure that money will only be spent on those who qualify and that those persons with the greatest needs will receive priority.

The program benefits do indicate an awareness of the "continuum of care", an important concept in long-term care. Respite care is offered either in the home or day care setting. This displays sensitivity to the varied needs of caregivers.

Under this plan, identified beneficiaries would be eligible for "chronic" home care. This adds homemaker and chore aid to the already existing Medicare home care services. This is a key aspect because the recipients would not be bound by the current tight restrictions on skilled home care.

Nursing home benefits would also be expanded to include chronic care. Like the expanded benefit under home care, we support the commitment to providing financial support for individuals requiring nursing home care.

Fundamentally, the philosophy of this bill is to be lauded. It is an attempt to ensure the future of long-term care delivery in our society.

As was mentioned earlier, Senator Mitchell, himself, states that this bill is not a panacea. There are costs involved, costs that may be prohibitive for some people.

First, as an expansion on Medicare, the basic Part B premium would be increased by $2/month and the pending supplemental premium set to a level to raise the same revenue as the increase in Part B. Many older adults are on fixed incomes. Those seniors, in poor health especially may be unlikely to afford any additional expenditures.

In addition to the increased premiums, substantial co-payments will be required. The respite care benefit of up to $2,000 requires a 50% co-pay ($1,000 per year). Chronic home care requires a $500 annual deductible and a 20% co-pay after the first twenty days post-hospitalization. There is also a Medicare expenditure cost cap, not to exceed 65% of SNF Medicare costs.

The development of support for chronic care patients is, indeed, a breakthrough. The patient cost of this component may, however, defeat the purpose of its existence. The beneficiary would be required to pay full-cost during a two year exclusionary period. After that, Medicare would reimburse at 70%. The writers of this bill do recognize the need for flexibility in patient financing of this care. The exclusionary period may be covered by insurance, reverse home equity, etc.

Even with these options, the tremendous cost of nursing care may force people to spend down to Medicaid. Medicaid will continue to cover the exclusionary period and the co-pay.

The financing of this entire program is not solely dependent on the increased premiums and beneficiary co-pay. This bill would also remove the $45,000 wage cap subject to the Hospital Insurance Tax. Also, a 5% gift surtax on transfers or inheritances over $200,000.

It is clear that the Long-Term Care Assistance Act is very well researched and thought-out. Its passage into law would be a dramatic step in reforming the current long-term care delivery system. The benefits reflect an open and innovative understanding of long-term health care needs. The financing is comprehensive. The fact that Medicaid will step in where the qualified beneficiaries can no longer afford the payments makes this program accessible to a larger number of Americans. We congratulate this work and support this act, not as the answer, but as a step towards a fully equitable and accessible long-term care system in this country.

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Statement
of the
Service Employees International Union

Families impoverished by long term care costs, elderly Americans relying on institutional care because home care is not available, and family care givers without relief from their chores, are among the serious problems in our long term care system.

The Service Employees International Union commends you for examining these problems and for proposing legislation to alleviate them. We are sympathetic to the broad outline of your legislation which would expand Medicare to encompass nursing home and home health care services. Yet we are concerned that the two year waiting period--during which the elderly are expected to rely upon private insurance for their needs--will pose an overwhelming barrier to the use of the new benefits.

How will older Americans fare during this two-year period before the public program begins to pay for nursing home care? Those who are well-off financially--and thus able to purchase top-of-the-line private insurance or pay out-of-pocket for services--will be unscathed. Unfortunately, the vast majority of moderate and low income Americans will continue on the current road of "spending down" to poverty and Medicaid. On average, 13 weeks elapse from the time a patient is admitted to a nursing home until the spouse left at home is impoverished.

This legislative proposal is an advantage for the wealthy--as well as for the insurance industry--but offers little protection or relief to most elderly Americans.

In addition, we have grave reservations about a program whose success depends on the private long term care insurance industry. In our view, the track record of this industry is dismal, and, without with a major overhaul and strict government regulation, we see little hope for improving its performance.

For instance, several recent studies demonstrated that the long term care insurance policies sold by these companies are not within the financial reach of low or moderate income people. According to the Consumers Union study, the monthly premiums are in the $100 to $250 range are common--an expense beyond most individuals and most employers. The Brookings Institutions's analysis of the industry projected that at best, by the year 2018, only one fourth to one half of the elderly will be able to afford a private insurance policy.

Moreover, the private long term care insurance industry lacks quality standards for its policies, has little government regulation, and holds a poor record of self-regulation--the experience with "Medi-gap" policies is the most recent example of this industry's exploitative bent.

Another quality concern is the value of the policies that are being sold. A variety of studies found that private long term care insurance policies include many restrictions: a majority of the plans examined by the Consumers Union required pre-hospitalization, even though most of the elderly are not hospitalized before they enter a nursing home; and many policies will not pay benefits for pre-existing conditions or for certain common diagnoses, such as Alzheimer's disease. These limitations mean that many of the elderly who buy policies will continue to shoulder significant out-of-pocket expenses.

Last, the private long term care insurance industry is inefficient. The Consumers Union study found excessive administrative and marketing costs among these providers, with many channelling 40 percent to 50 percent of premiums to their administrative costs.

A long term care reform package that hinges on private insurance is not viable, in our view. The historical experience with this industry reveals major questions about cost, quality, and access.

Despite budgetary constraints, we believe that the initial pieces of a publicly-funded comprehensive long term care plan should be put into place now, rather than committing to a system patched together with private insurance plans of questionable value.
We stand with you, committed to reforming our long term care system, and we look forward to working with you to refine this legislation.

Long-Term Care Insurance

A National Need...

A Response

U.S. Office of Personnel Management
Washington, D.C. 20415

September 1987

The Need for Long-term Care

- The over-65 population is growing faster than the population as a whole. In 1980 there were 25.5 million Americans over 65. In 2000, it is projected that 34.9 million will be over 65. Today, there are about 2.5 million Americans over 85, 8 million is the projection for 2020.
- Out-of-pocket payments for long-term care are the leading cause of catastrophic health expenditures. Approximately 43% of the over-65 population can expect to spend some time in a long-term care facility.
- At an average cost of $67 a day, a stay in a nursing home can cost between $20,000 and $40,000 a year.
- Less than 1% of the nation's population has any private insurance coverage for long-term care services.

The Implications for Federal Employees

For most purposes, Federal employees are well insured. The Federal Government has offered group life insurance benefits to the workforce since 1954 and group health insurance since 1960. Like most other Americans, however, Federal employees have no protection against the catastrophic costs associated with long-term care for chronic, debilitating illness and few vehicles are available in the current market place to provide such protection. For Federal employees, as for Americans generally, the most significant uninsured event of potentially catastrophic impact is the expense associated with nursing home or other long-term care arrangements.

The Proposal

Federal employees would be given an opportunity to protect themselves from the devastating costs of long-term care by adding a new option to the current life insurance program (known as FEGLI).

Through a competitive selection process, the Office of Personnel Management (OPM) would select several private sector insurers offering varying benefit levels to participate in the new Federal employee long-term care option.

Here's how the proposed option would work:

- When an employee reached a minimum age of 50 with 10 years' participation in FEGLI, he would be given an opportunity to convert to long-term care insurance;
- He would convert a portion of the face value of his Basic FEGLI insurance (e.g., $25,000) and associated reserve funds to long-term care insurance and would retain a minimum $2,000 death benefit;
- He would continue to pay his share of the regular Basic FEGLI premium for any amount of life insurance remaining and would pay an additional long-term care premium based on his age at conversion;
- He would receive stated dollar benefits for nursing home or alternative home health care;
- He would be eligible to purchase coverage for his spouse at group rates and without evidence of insurability, and to purchase additional life insurance.
- The Government would continue to pay its usual contributions for Basic FEGLI but contributions associated with converted life insurance would be redirected to the long-term care option. (There is no additional cost to the Government.)
- Premium rates and dollar benefits would rise automatically with increases in the General Schedule pay scale. Additional inflation protection might be available in some plans.

Because not everyone would be interested in long-term care insurance, participation in the program would be entirely voluntary. Further, employees ineligible for the FEGLI conversion, or who for any reason do not wish to convert, could elect the long-term care option and pay the full cost of their coverage.

Why Use the Life Insurance Program To Solve a Health Insurance Problem?

- As an employee reaches his mature years, his need for large amounts of life insurance coverage decreases and his need for long-term care insurance increases. Instead of carrying a large amount of life insurance coverage into retirement, as is the current practice, many employees would be better served if their Basic coverage and the reserve funds associated with it could be converted to long-term care insurance.
- Long-term care presents a special funding difficulty. While health insurance is generally priced to cover the near-term health costs of the affected group, long-term care would best be financed by setting aside funds today for a need which may not arise for many years in the future. The life insurance program provides such long-term financing.
- Employees who need to retain large amounts of life insurance could opt for long-term care conversion since they would still have access to the optional coverages under FEGLI which provide death benefits of up to five times salary.

Why Act Now?

- The need for long-term care will reach crisis proportions soon, yet most Americans are largely unaware of the impending threat to their financial well-being.
- By acting now we can educate our work force -- and Americans generally -- concerning their vulnerability to chronic illness and their need for long-term care.
- We will be able to keep the price of protection low enough so that people in their middle years will be motivated to buy insurance they are likely to need in old age.

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